Reset Form

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Women's Health Partners, LLC

Diplomates of the American Board of Obstetrics & Gynecology

Name: _____

Patient Health History Questionnaire

Reason for your visit: _____

PAST MEDICAL HISTORY: (Do you have or have you ever had): ☐ None

- ☐ Alzheimer's Disease
- ☐ Anemia
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Breast Cancer
- ☐ Cardiac Arrhythmia
- ☐ Cervical Cancer
- ☐ Cholesterol, elevated
- ☐ Colon Cancer
- ☐ Congestive Heart Disease
- ☐ COPD (Lung Disease)
- ☐ Coronary Heart Disease
- ☐ Depression
- ☐ Diabetes Mellitus
- ☐ DVT (Venous embolism)
- ☐ Epilepsy
- ☐ Esophageal Reflux
- ☐ Fibromyalgia
- ☐ Hepatitis (A, B, or C)
- ☐ Hernia
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Irritable bowel syndrome
- ☐ Kidney stone
- ☐ Kidney Failure
- ☐ Lung Cancer
- ☐ Migraine Headache
- ☐ Mitral Valve Prolapse
- ☐ Myocardial Infarction
- ☐ Osteoporosis
- ☐ Ovarian Cancer
- ☐ Pulmonary Embolism
- ☐ Skin Cancer
- ☐ Stomach Cancer
- ☐ Stress Incontinence
- ☐ Stroke (CVA)
- ☐ Transient ischemic attack
- ☐ Ulcer
- ☐ Uterine Cancer

Comments: _____

PAST GYNECOLOGIC HISTORY: (Do you have or have you ever had): ☐ None

- ☐ Abnormal PAP Smear
- ☐ Amenorrhea (no menses)
- ☐ Anovulation
- ☐ Bartholin's gland cyst
- ☐ Cervical Cancer
- ☐ Candidiasis (chronic yeast)
- ☐ Chlamydia
- ☐ Condyloma Acuminatum
- ☐ Cystocele (dropped bladder)
- ☐ Cytomegalovirus disease
- ☐ DES Exposure in utero
- ☐ Dysplasia (abnormal paps)
- ☐ Dysfunctional Bleeding
- ☐ Dysmenorrhea
- ☐ Dyspareunia (painful sex)
- ☐ Ectopic
- ☐ Endometriosis
- ☐ Fibroid uterus
- ☐ Gonorrhea
- ☐ Herpes Simplex (HSV)
- ☐ Hirsutism
- ☐ Human Papilloma Virus
- ☐ Hydrosalpinx
- ☐ Incontinence
- ☐ Infertility
- ☐ Irregular menses
- ☐ Menorrhagia (heavy menses)
- ☐ Ovarian cyst
- ☐ Pelvic adhesions
- ☐ Pelvic inflammatory disease
- ☐ PMS
- ☐ Polycystic ovaries (PCOS)
- ☐ Recurrent vaginitis
- ☐ Syphilis
- ☐ Trichomonas
- ☐ Uterine polyps
- ☐ Uterine prolapse
- ☐ Uterine scar tissue

Comments: _____

REPRODUCTIVE & MENSTRUAL HISTORY:

Total # of pregnancies	# of Full Term	# of premature pregnancies	# of terminations	# of miscarriages	# of ectopics	# of multiple births	# living

Date of last menstrual period: _____

Certainty of last menstrual period: _____

Menopause status: _____

Home pregnancy test: _____

Method of birth control: _____

On hormone replacement: _____

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PAST SURGICAL HISTORY: ☐ None

☐ Adenoidectomy	☐ Cystoscopy	☐ Laparoscopy	_____
☐ Appendectomy	☐ D&C	☐ LASIK (eye correction)	_____
☐ Back surgery	☐ Ectopic Pregnancy	☐ LEEP (Cervical Cone biopsy)	_____
☐ Breast augmentation	☐ Endometrial ablation	☐ Ovary Removal	_____
☐ Breast lumpectomy	☐ Gastric Bypass	☐ Pacemaker implant	_____
☐ Breast mastectomy	☐ Hemorrhoid	☐ Shoulder surgery	_____
☐ Bladder lift	☐ Hernia	☐ Sinus surgery	_____
☐ C/Section	☐ Hip replacement	☐ Splenectomy	_____
☐ CABG (coronary bypass)	☐ Hysteroscopy	☐ Thyroidectomy	_____
☐ Cataracts	☐ Hysterectomy (abdominal)	☐ Tonsillectomy	_____
☐ Cholecystectomy/Gallbladder)	☐ Hysterectomy (vaginal)	☐ Tubal ligation	_____
☐ Colon resection	☐ Hysterectomy-laparoscopic	_____	_____
☐ Colonoscopy	☐ Knee surgery	_____	_____

Comments: _____

_____

GENETIC HISTORY: ☐ None

☐ Baby with birth defects	☐ Hemophilia	☐ Tay-Sachs disease	_____
☐ Chromosomal disorder	☐ Mental retardation	☐ Thalassemia	_____
☐ Cystic fibrosis	☐ Muscular dystrophy	_____	_____
☐ Down's Syndrome	☐ Neural tube defects	_____	_____
☐ Fragile X	☐ Sickle cell anemia	_____	_____
☐ Genetic/Inherited disorder	☐ Spinal Muscular Atrophy	_____	_____

Comments: _____

_____

MEDICATIONS: ☐ None

	Medication	Dosage	Frequency	Reason
1.				
2.				
3.				
4.				
5.				
6.				

ALLERGIES: ☐ None

	Medication or Substance	Reaction		Medication or Substance	Reaction
1.			3.		
2.			4.		

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FAMILY HISTORY:

☐ None

	Age	Heath Problem or cause of death
Father:		
Mother:		
Siblings:		
Children:		
Uncles / Aunts:		
Grandparents:		

GENERAL HEALTH SCREENING:

Date of last Pap smear: _____ Date of last Colonoscopy: _____

Date of last Mammogram: _____ Date of last Bone Density Scan: _____

	Yes	No		
Do you smoke?	☐	☐	If so, how much?	and for how long?
Have you ever smoked?	☐	☐	If so, how much?	and for how long?
Do you drink regularly?	☐	☐	If so, how many drinks per week?	
Do you smoke marijuana ?	☐	☐	If so, how many joints per week?	
Do you use other recreational drugs?	☐	☐	If so, which ones?	
Do you exercise regularly?	☐	☐		
Do you perform monthly breast exam?	☐	☐		
Is your diet low in fat?	☐	☐		
Do you use seat belts?	☐	☐		
Do you ingest 1000mg of Calcium a day?	☐	☐		

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Instructions: Please circle "Y" to those that apply to YOU and/or YOUR FAMILY (on both your **mother's** or **father's** side). Behind each statement, please list the relationship to you of the individual diagnosed (such as self, paternal uncle, maternal aunt, paternal grandmother) and their age at diagnosis. Each statement should be answered individually, so you may list the same cancer diagnosis more than once as you answer these questions.

BREAST AND OVARIAN CANCER

Yes	No		RELATIONSHIP	AGE AT DIAGNOSIS
☐	☐	- Breast cancer before 50		
☐	☐	- Ovarian cancer		
☐	☐	- Breast cancer in both breast or multiple primary breast cancers		
☐	☐	- Both breast & ovarian cancer (in an individual or family)		
☐	☐	- Male breast cancer		
☐	☐	- 2 or more breast or ovarian cancers (in an individual or family)		
☐	☐	- Ashkenazi Jewish ancestry & personal or family history of breast or ovarian cancer		

COLON AND UTERINE CANCER

Yes	No		RELATIONSHIP	AGE AT DIAGNOSIS
☐	☐	- Uterine cancer before 50		
☐	☐	- Colorectal cancer before 50		
☐	☐	- Both uterine & colorectal cancer (in an individual or family)		
☐	☐	- 2 or more uterine or colorectal cancers (in an individual or family)		
☐	☐	- Uterine and/or colorectal cancer AND ovarian, stomach, kidney/urinary tract, brain or small bowel cancer (in an individual or family)		

COLON POLYP HISTORY

Yes	No		RELATIONSHIP	AGE AT DIAGNOSIS
☐	☐	- 10 or more colon polyps found in lifetime		