HEALTH HISTORY QUESTIONNAIRE

Name: _____ Date: _____

Age: _____ Marital Status: ☐ Single ☐ Married (How many Years: _____) ☐ Divorced ☐ Widowed

Reason you came to see the doctor: _____

List any Medication you are **ALLERGIC** to:

_____

_____

Check or List any Medical Problem that applies to you:

☐ High Blood Pressure ☐ Heart Disease ☐ Diabetes
☐ Asthma/Lung Disease ☐ Kidney Disease ☐ Bleeding Disorder
☐ Breast Disease ☐ Cancer ☐ Depression/Mental Illness
Other/Remarks: _____

List any MEDICATIONS you are currently taking:

_____

_____

_____

List any OPERATIONS/HOSPITALIZATIONS and the year it took place:

_____

_____

_____

Menstruation: Started at age _____, Number of days from start of one period to start of next period _____ .
Number of days period lasts _____ . Date of last normal menstrual period (1st day) _____ .

Obstetrical History: How many times have you been pregnant? _____ .
How many Full-term babies? _____ , Premature? _____ , Miscarriages? _____ , Abortions? _____ .

Date of Birth	Weeks Pregnant	Weight	Sex M/F	Type of Delivery (Vaginal, C-section, Forceps, …)	Place/Doctor	Complications?/Remarks?

Last Pap Smear: _____ Results: _____ Any History of Abnormal Pap Smear? _____

Do you smoke? If so, how much per day? _____For how many years?_____. Do you drink? If so, how much per week? _____.

When was your last Mammogram? _____ When was your last Bone Density? _____ When was your last Colonoscopy? _____

Current age of Mother (or age died & cause): _____ Father: _____
Record history of any family member's medical problems including Heart Disease, Diabetes, Cancer, Birth Defects, etc. _____
_____

Please check any of the following if they apply to you (Check "☐Y" for Yes and "☐N" for No)

General:
Weight change ☐Y ☐N
Fever ☐Y ☐N
Fatigue ☐Y ☐N
Other _____

Head/Eyes/Ears/Nose/Throat:
Visual changes ☐Y ☐N
Hearing changes ☐Y ☐N
Other _____

Cardiovascular:
Chest pain ☐Y ☐N
Shortness of breath ☐Y ☐N
Palpitations ☐Y ☐N
Swelling ☐Y ☐N
Other _____

Respiratory:
Shortness of breath ☐Y ☐N
Cough ☐Y ☐N
Wheezing ☐Y ☐N
Other _____

Endocrinologic:
Diabetes ☐Y ☐N
Fatigue ☐Y ☐N
Too hot/cold ☐Y ☐N
Other _____

Gastrointestinal:
Abdominal pain ☐Y ☐N
Nausea/vomiting ☐Y ☐N
Diarrhea ☐Y ☐N
Constipation ☐Y ☐N
Bloody stools ☐Y ☐N
Other _____

Genitourinary:
Frequency ☐Y ☐N
Urgency ☐Y ☐N
Pain with urination ☐Y ☐N
Blood in urine ☐Y ☐N
Incontinence ☐Y ☐N
Nighttime urination ☐Y ☐N
Other _____

Gynecologic:
Irregular periods ☐Y ☐N
Painful periods ☐Y ☐N
Heavy periods ☐Y ☐N
Pain with intercourse ☐Y ☐N
Discharge or odor ☐Y ☐N
Itching ☐Y ☐N
Lesions/sores ☐Y ☐N
Mass/pressure ☐Y ☐N
Other _____

Menopausal Symptoms:
Hot flashes/sweats ☐Y ☐N
Sleep disturbances ☐Y ☐N
Depression irritability ☐Y ☐N
Other _____

Breast:
Breast pain ☐Y ☐N
Breast mass/lump ☐Y ☐N
Nipple discharge ☐Y ☐N
Other _____

Neurologic:
Headaches ☐Y ☐N
Fainting ☐Y ☐N
Numbness/tingling ☐Y ☐N
Weakness ☐Y ☐N
Other _____

Psychologic:
Depression ☐Y ☐N
Anxiety ☐Y ☐N
PMS ☐Y ☐N
Other _____

Hematologic:
Bruising ☐Y ☐N
Unexpected bleeding ☐Y ☐N
Swollen glands ☐Y ☐N
Other _____

Skin:
Rash ☐Y ☐N
Lesions ☐Y ☐N
Other _____