HEALTH HISTORY QUESTIONNAIRE

Name_____ Birthdate _____

Reason For Visit: _____ Primary Care Physician: _____

Pharmacy #1: _____ City: _____ Location: _____
Pharmacy #2: _____ City: _____ Location: _____
Emergency Contact Name: _____ Phone Number: _____
Email Address: _____
Age when you started having periods: _____ **Date of Last Menstrual Period:** _____

Number of pregnancies_____ Full term deliveries_____ Pre term deliveries _____
Miscarriage/Abortions_____ Living Children _____ **Are you currently pregnant?** ____

Allergies **ARE YOU ALLERGIC TO LATEX?** □ No □ Yes

Allergy (Medication or Environmental)	Reaction

Please include all over the counter medications and prescription medications.

Medication	Dose/Strength	# of pills/amt	times/day

Medical History

Please check if you have or have ever been diagnosed with any of the following conditions:

__Anemia
__Arthritis
__Asthma
__Blood Clot
__Blood Transfusion
__Chronic Urinary Infection
__Crohn's Disease
__Diabetes (type_____)
__Diverticulitis
__Elevated Cholesterol
__Epilepsy
__Fibromyalgia
__Heart Disease
  __Angina
  __Congestive heart failure
  __Coronary artery disease
  __Mitral valve prolapse
__Heartburn/Reflux
__Hepatitis (type_____)
__High Blood Pressure
__Irritable Bowel Syndrome
__Kidney Stones
__Lupus
__Migraines
__Psychiatric Disorder
  __Bipolar Disorder __Depression
  __Obsessive/Compulsive __Schizophrenia
__Stroke
__Thyroid Disorder
  __Hyperthyroid __Hypothyroid
  __Goiter __Graves Disease
_Other _____
_____
_____

GYN PROBLEMS

__Abnormal Pap Smears
__Bartholin Cyst
__Breast Cancer
__Breast Lump
__Cervical Cancer
__Cervical Dysplasia
__Chronic Vaginal Infections
__Chronic Pelvic Pain
__Endometrial Hyperplasia
__Endometriosis
__Fibrocystic Breast
__Habitual Aborter(> 3 Miscarriages)
__Infertility
__Ovarian Cancer
__Ovarian Cyst
__Heavy Bleeding
__Irregular Period
__Lichen Sclerosis
__Pelvic Inflammatory Disease
__Prolapse
__Sexually Transmitted Disease
    __Chlamydia
    __Genital Warts
    __Gonorrhea
    __Herpes
    __Trichomonas
__Urinary Incontinence
__Uterine Cancer
__Uterine Fibroids
__Other_____

SURGICAL HISTORY

Have you ever had any of the following surgeries and if so when.

	Age	Yr
__Arthroscopy (_____)		
__Appendectomy/Appendix		
__Cataracts		
__Cardiac Surgery (_____)		
__Cystoscopy		
__Gallbladder Removed		
__Hip Replacement R or L		
__Knee Replacement R or L		

	Age	Yr
__Sinus Surgery		
__Tonsillectomy		
__Tonsillectomy/Adenoids		
__Tubes in ears		
__Wisdom Tooth Extraction		
_____		
_____		
_____		

GYN SURGICAL HISTORY

	Age	Yr
__Breast Augmentation		
__Breast Biopsy		
__Breast Reduction		
__Cesarean Section		
__Cervical Procedures		
__Cone Biopsy		
__Cryo		
__Laser		
__LEEP		
__Colposcopy		
__D & C		

	Age	Yr
__Endometrial Ablation		
__Hysteroscopy		
__Hysterectomy Abd / Vag		
__Laparoscopy		
__Laparotomy		
__Mastectomy R / L / B		
__Ovaries Removed R / L / B		
__Tubal Ligation		
_____		
_____		
_____		

FAMILY MEDICAL HISTORY

Please check if anyone in your immediate family has been diagnosed or treated for the following:

Adopted ☐

	Mother	Father	Sister	Brother	Daughter	Son	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Breast Cancer										
Colon Cancer										
Ovarian Cancer										
Uterine Cancer										
Diabetes										
Hypertension										
Stroke										
Heart Disease										
Thyroid Disorder										
Osteoporosis										
Kidney Problems										
Epilepsy										
Lung Disease										

OBSTETRICAL HISTORY

Please fill out for each pregnancy even if it was a miscarriage or abortion.

If you've had a tubal ligation, hysterectomy, or are over the age of 50, only date and type of delivery are necessary.

Preg #	Type of Delivery	Date MM/YY	Baby Name	Gestational Age	Wt	Sex	Hospital	Doctor	Complications
	Miscarriage Vaginal Delivery C-Section Abortion			Term Preterm		M / F			
	Miscarriage Vaginal Delivery C-Section Abortion			Term Preterm		M / F			
	Miscarriage Vaginal Delivery C-Section Abortion			Term Preterm		M / F			
	Miscarriage Vaginal Delivery C-Section Abortion			Term Preterm		M / F			
	Miscarriage Vaginal Delivery C-Section Abortion			Term Preterm		M / F			
	Miscarriage Vaginal Delivery C-Section Abortion			Term Preterm		M / F			

SOCIAL HISTORY

Race: □ African-American □ Asian □ Caucasian □ Hispanic □ Other: _____

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino

Primary Language: □ English □ Spanish □ Vietnamese □ Other:

Gender Assigned at Birth: □ Female □ Male □ Declined

Gender Identity: □ Female □ Female-to-Male (Transgender Male) □ Male-to-Female (Transgender Female) □ Genderqueer (Neither exclusively male nor female) □ Declined

Marital Status: □ Married □ Divorced □ Legally Separated □ Single □ Widowed □ Engaged □ Domestic Partner

Occupation: _____ □ Unemployed □ Disabled

Place of Employment: _____

Diet: □ Diabetic □ Healthy □ High Fat □ Low Fat □ Low Sodium □ Junk Food

Exercise: □ 2-3x/week □ 3-4x/week □ Daily □ Never □ Occasional □ Rarely

Caffeine Intake: Type: □ Coffee □ Tea □ Soda Amount: _____

Tobacco Use: □ No □ Yes □ Former
Type: _____ Amt/day: _____ #Years: _____ Year Quit: _____

Alcohol Use: □ No □ Yes □ Former Frequency: _____ Year Quit: _____

Illicit Drug Use: □ No □ Yes □ Former
Type: _____ #Years: _____ Year Quit: _____

HEALTH MAINTENANCE

Date of Last Pap Smear: _____ **Result:** _____

Date of Last Mammogram: _____ **Result:** _____

Date of Last Colonoscopy: _____ **Result:** _____

Date of Last Bone Density: _____ **Result:** _____

Date of Last Cholesterol Test: _____ **Result:** ___normal / elevated_____

Chicken Pox Status: □ I have had chicken pox □ I have had the chicken pox vaccine
□ I have had the vaccine and chicken pox □ I have had neither the vaccine nor chicken pox

Hepatitis B:
□ I have received the entire Hepatitis B vaccination series
□ I have part of the Hepatitis B vaccination series
□ I have not received the Hepatitis B vaccination series

Gardasil Vaccine:
□ I have received the entire Gardasil vaccination series
□ I have part of the Gardasil vaccination series _____ injections.
□ I have not received the Gardasil vaccination series

Date of Last Flu Vaccine: _____ **Date of Last Tetanus Vaccine:** _____
Date of Last Pneumonia Vaccine: _____ **Date of Last MMR Vaccine:** _____