

## HEALTH QUESTIONNAIRE

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

### WHAT IS THE REASON FOR TODAY'S VISIT? (PLEASE CIRCLE)

Pap Smear Birth Control Infection Bleeding Pregnancy Other \_\_\_\_\_

If you have a problem, how long have you had it? \_\_\_\_\_

Have you consulted anyone before for this problem? Yes No Name of Physician: \_\_\_\_\_

### GYN SYSTEM REVIEW

When was your last period? \_\_\_\_\_ How many days did it last? \_\_\_\_\_

How old were you when your periods started? \_\_\_\_\_ How often do they come? \_\_\_\_\_ How often do they last? \_\_\_\_\_

Do you have: Bleeding between periods? Yes No Bleeding after intercourse? Yes No Painful periods? Yes No

Do you take medication for your period? If so, what medication: \_\_\_\_\_

When was your last PAP? \_\_\_\_\_ If you have ever had an abnormal pap, when and how were you treated? \_\_\_\_\_

When was your last Mammogram? \_\_\_\_\_

Do you have a discharge? Yes No If yes, please describe nature of discharge and prior treatments: \_\_\_\_\_

Do you take hormones? Yes No What kind and how often? \_\_\_\_\_

Have you ever had a Sexually Transmitted Disease? (Gonorrhea, Chlamydia, Herpes, Warts) \_\_\_\_\_

### BIRTH CONTROL: (If you are using or have used birth control, please fill in below)

<u>METHOD</u>	<u>DATE</u>	<u>BRAND</u>	<u>DOSE</u>	<u>REASON FOR STOPPING</u>
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Pill \_\_\_\_\_

IUD \_\_\_\_\_

Tubal Ligation \_\_\_\_\_

Other \_\_\_\_\_

### OBSTETRIC HISTORY: (If less than 65yrs old, please fill in below)

Deliveries:		# of Months	Length of	Birth	Sex of	
Date	Wt. Gain	Pregnant	Labor	Weight	Baby	Complications

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Miscarriages:	Length of		
Date	Pregnancy	Treatment	Complications

\_\_\_\_\_

\_\_\_\_\_

Terminations of Pregnancy:	Length of		
Date	Pregnancy	Treatment	Complications

\_\_\_\_\_

\_\_\_\_\_

### YOUR PERSONAL PAST MEDICAL HISTORY: (Have You had any of the below? Please check and supply the year)

Abnormal Pap _____	Heart Disease _____	Pneumonia _____
Anemia _____	High Blood Pressure _____	Gyn. Disease _____
Asthma _____	Intestinal Problems _____	Blood Transfusion _____
Cancer _____	Kidney Problems _____	Rheumatic Fever _____
Diabetes _____	Liver Disease _____	Urinary Tract Inf. _____
Epilepsy _____	Migraines _____	Stroke _____
Gall Bladder Disease. _____	Phlebitis _____	Thyroid Problems _____

Have you ever had a Colonoscopy? If so when \_\_\_\_\_ Have you ever had a Bone Density Exam? If so when \_\_\_\_\_

**Have you recently had any of the following problems?** (Please check all that apply)

Loss of Urine	_____	Cough	_____
Severe Headaches	_____	Breathing Problems	_____
Visual Changes	_____	Chest Pain	_____
Deafness	_____	Leg Cramps	_____
Nausea / Vomiting	_____	Missed Periods	_____
Trouble Swallowing	_____	Weight Gain/Loss	_____
Heartburn	_____	Change in Hair Growth	_____
Rectal Bleeding	_____	Leakage from Nipples	_____
Burning with Urination	_____	Lump in Breast	_____

**FAMILY HISTORY** (Does anyone in your family have any of the following? Please indicate who, i.e., father, mother, sister, brother... etc.)

Alcohol/Drug Abuse	_____	High Blood Pressure	_____
Psychiatric	_____	Kidney Problems	_____
Sugar Diabetes	_____	Stroke	_____
Glaucoma	_____	Thyroid Problems	_____
Heart Disease	_____	Tuberculosis	_____
Breast/Gyn Cancer	_____	Colon/Rectal Disease	_____
Epilepsy	_____	Liver Disease	_____

**Your race/ethnicity is:** (Please circle all that apply)

White Black Chinese Japanese Korean Cambodian Laotian Vietnamese Southeast Asia Filipino Hawaiian  
 Native American Middle Eastern Asian-East Indian Samoan Unknown Hispanic Other \_\_\_\_\_

**PREVIOUS SURGERY:**

Date	Procedure	Hospital	Location	Surgeon	Complications
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Have you ever been in the **HOSPITAL** for anything not yet discussed?

Date	Hospital	Locations	Reason	Duration	Complications
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Please provide the name(s) of any prescription medications, over the counter medications, herbs and/or vitamins you are currently taking: \_\_\_\_\_

Are you **ALLERGIC** to any medications or **LATEX**? Yes No **If yes, please explain and include the name of the medication(s) and reaction:**

Do you <b>SMOKE</b> ?	Yes	No	How many a day?	_____
Do you <b>DRINK</b> ?	Yes	No	How much a day?	_____
Do you use <b>DRUGS</b> ?	Yes	No	How often?	_____
Do you have a history of anxiety, depression or mental illness?	Yes	No		_____
Do you have a history of trauma or violence?	Yes	No		_____
Do you have a special diet?	Yes	No		_____

Are there any other matters you wish to discuss? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_