

HEALTH QUESTIONNAIRE

(The purpose of this questionnaire is to assist the doctor with your care.)

Date: _____
 Name _____ Age _____ Birth Date _____ Occupation _____
 Education _____ Religion _____
 Circle: Single, Married(____yrs), Widow, Divorced, Separated. **Date of last Physical Exam:** _____
 Circle the **MAIN** reason you came to see the doctor: Pain, Menstrual, Problem, Pregnancy, Urinary Problem,
 Birth Control, Routine Check, Pap, Infertility, Other: _____

Note: This is part of your medical record and is kept confidential, and will not be release to anyone without your written consent
Please circle YES or NO

Family History	LIVING		DECEASED cause
	Age	Health	
Father			
Mother			
Siblings 1			
2			
3			
4			
Husband			
Children 1			
2			
3			

Disease in Blood Relatives	WHO
Cancer	Yes No _____
Colon	Yes No _____
Breast	Yes No _____
Uterine	Yes No _____
Ovarian	Yes No _____
Prostate	Yes No _____
Melanoma	Yes No _____
Diabetes	Yes No _____
Elevated Cholesterol	Yes No _____
High Blood Pressure	Yes No _____
Osteoporosis	Yes No _____
Mental Illness	Yes No _____
Birth Defects	Yes No _____
Twins	Yes No _____
Cesarean	Yes No _____
Blood Disorders (type)	Yes No _____
Genetic Disorders (type)	Yes No _____
Other	Yes No _____

HEIGHT _____
 WEIGHT _____ One year ago _____
 Maximum _____ when _____
 Have you ever been hospitalized for any illness?
 Yes No Give Details _____

<p>PREVIOUS SURGERY</p> <p>Tonsils Yes No Appendix Yes No Gallbladder Yes No Breast (including reduction/ Augmentation) Yes No Thyroid Yes No Laparoscopy Yes No Dilation & Curettage Yes No Hysterectomy Yes No Ovaries Yes No Tubes Yes No Cesarean Yes No Sigmoidoscopy/ Yes No Colonscopy Yes No Blood Transfusion Yes No Other: List Yes No</p> <p>Have you ever been advised to have Any surgical operation which has not Been done? Yes No</p> <p>ALLERGIES</p> <p>Penicillin Yes No Sulfa Yes No</p>	<p>PERSONAL HISTORY</p> <p>ALLERGIES (CONT.)</p> <p>Tetracycline Yes No Antibiotics Yes No Lidocaine/Anesthetics Yes No Codeine Yes No Other Drugs Yes No Foods Yes No Iodine Yes No Latex Yes No Other Yes No</p> <p>DO YOU USE</p> <p>Caffeine Yes No Tobacco Yes No Alcohol Yes No Social/ Recreational drugs Yes No</p> <p>CURRENT MEDICATIONS</p> <p>Laxatives Yes No Vitamins Yes No Herbal Therapies Yes No Chinese Medicine Yes No Tranquilizer Yes No Sleeping pills Yes No</p>	<p>CURRENT MEDS (CONT.)</p> <p>Thyroid Yes No Diet Pills Yes No Water Pills Yes No Heart Pills Yes No Blood Pressure Pills Yes No Hormones Yes No Birth Control Yes No Aspirin/Ibuprofen Yes No Others Yes No</p> <p>CHILDHOOD ILLNESSES</p> <p>Measles Yes No Mumps Yes No Chicken Pox Yes No Scarlet Fever/ Rheumatic Fever Yes No Rubella (German Measles) Yes No</p> <p>ADULT ILLNESSES</p> <p>Pneumonia Yes No Tuberculosis Yes No</p>
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ADULT ILLNESSES(CONT.)

Asthma	YES NO	Hemorrhoids	YES NO	Recurrent Bladder	
Cancer	YES NO	Irritable bowel	YES NO	Infections	YES NO
Diabetes	YES NO	Seizure/	YES NO	Meningitis/	
Thyroid Disease	YES NO	Convulsions	YES NO	Encephalitis	YES NO
Arthritis	YES NO	Mental Illness/	YES NO	Mitral Valve Prolapse requiring	
Osteoporosis	YES NO	Depression	YES NO	an antibiotic for	
Back Trouble	YES NO	Phlebitis or	YES NO	procedures	YES NO
Anemia	YES NO	Blood Clots	YES NO	Heart attack/	
Jaundice/Hepatitis	YES NO	Migraines	YES NO	angina	YES NO
Ulcer	YES NO	Varicose Veins	YES NO	Stroke (CVA)	YES NO
Gallbladder		Kidney Disease	YES NO	Exposed to or tested positive	
Disease	YES NO	Mononucleosis	YES NO	for HIV	YES NO

AS OF NOW DO YOU HAVE ANY OF THESE SYMPTOMS?

Appetite changes	YES NO	Unusual growth of hair	YES NO	Nervousness	YES NO
Weight gain or loss	YES NO	Extreme temperature		Get up at night to urinate	YES NO
Fatigue	YES NO	sensitivity	YES NO	Hot flashes	YES NO
Skin rash or irritation	YES NO	Enlarged glands	YES NO	Problems sleeping	YES NO
Change in skin pigment	YES NO	Breast pain	YES NO	Sudden urge to urinate	YES NO
Headaches	YES NO	Breast lump	YES NO	Lose of urine when cough	
Visual changes	YES NO	Chest pain	YES NO	or laugh	YES NO
Hearing problems	YES NO	Productive cough	YES NO	Muscle pain or cramping	YES NO
Ear infections/earaches	YES NO	Cough up blood	YES NO	Pain/Stiffness/Swelling	
Hair Loss	YES NO	Shortness of breath	YES NO	of joints	YES NO
Vertigo	YES NO	Heartburn	YES NO	Swelling or water	
Sinus problems	YES NO	Nausea	YES NO	retention	YES NO
Nose bleeds	YES NO	Vomiting	YES NO	Pain or decreased motion	
Excessive bleeding		Blood in vomit	YES NO	back or neck	YES NO
From cuts	YES NO	Abdominal pain	YES NO	Broken bones	YES NO
Bruise easily	YES NO	Diarrhea	YES NO	Dizziness	YES NO
Sore throat or		Constipation	YES NO	Loss of consciousness	YES NO
Hoarseness	YES NO	Recurrent disease	YES NO	Emotional/Psychiatric	
Trouble swallowing	YES NO	Rectal bleeding	YES NO	problems	YES NO
Bleeding or sore gums	YES NO	Frequency of urination	YES NO	Paralysis	YES NO
Recurrent sores		Painful urination	YES NO	Numbness	YES NO
In mouth	YES NO	Blood in urine	YES NO	Chills or fever	YES NO
				Night sweats	YES NO

GYNECOLOGICAL HISTORY

Menses started at age _____ regular _____ irregular _____ Date of last menstrual period _____ Date of menopause _____
 Average number of days from start of one period to the next period _____ Number of days bleeding lasts _____
 Date of last NORMAL period (1st day) _____ Menstrual flow is usually: scant _____ moderate _____ heavy _____ Clots: **YES NO**
 Are your periods painful? **YES / NO** If yes, describe _____ Have you ever been diagnosed with Endometriosis? **YES / NO**
 Do you have a history of Ovarian Cysts? **Yes NO** Do you ever bleed between periods? **YES / NO**
 Do you bleed after intercourse or douching? **YES/NO** Do you get tense before periods? **YES/ NO** Do you have any sores or rashes? **YES /NO**
 Have you ever been treated for pelvic infection before? **YES / NO** Do you have a discharge **YES / NO** color? _____ Odor? **YES / NO**
 Itch? **YES / NO** Have you ever been treated for a vaginal infection before?
 Fungus-yeast **YES /NO** Herpes **YES / NO** Do you douche? **YES / NO** how often? _____
 Bacterial vaginosis **YES / NO** Venereal warts (HPV) **YES / NO** DES exposure in utero **YES / NO**
 Gonorrhea **YES / NO** Chlamydia **YES / NO** Syphilis **YES / NO** Other **YES / NO**
 Length of time with current partner? _____
 Date of last PAP SMEAR _____
 Date of last MAMMOGRAM _____
 Do you have a history of abnormal pap smears? **YES / NO**
 If yes, what treatment was used? Cryosurgery _____
 Laser surgery _____
 Cone biopsy _____

OBSTETRICAL HISTORY

How many pregnancies have you had _____
 How many children born alive _____
 How many sets of twins do you have _____
 How many cesarean births _____
 How many premature births _____
 How many miscarriages _____
 How many abortions _____
 How many tubal/ectopic pregnancies _____
 How many stillbirths _____

CONTRACEPTIVE HISTORY

Are you trying to get pregnant? **YES / NO**
 Do you have trouble getting pregnant? **YES / NO**
 Do you or your partner use a birth control method? **YES / NO**
CHECK METHOD:
 Natural/Rhythm _____ Vaginal Suppository _____ Norplant _____
 Withdrawal _____ Vaginal Film _____ Tubal _____
 Abstinence _____ Sponge _____ Vasectomy _____
 Rubber Condom _____ Diaphragm _____ Patch _____
 Foam _____ Cervical Cap _____ Depo _____
 IUD _____ Pill _____ Other _____
 Comments or problems with method: _____