

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 _____