

**HEALTH QUESTIONNAIRE**

Date: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Name: \_\_\_\_\_

Age: \_\_\_\_\_

Preferred Name: \_\_\_\_\_

Spouse or Closest Relative: \_\_\_\_\_

Occupation: \_\_\_\_\_

Phone: \_\_\_\_\_

Referred by (MD, relative, friend?): \_\_\_\_\_

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Any Current Problems: \_\_\_\_\_

Allergies (medications): \_\_\_\_\_

Present medications: \_\_\_\_\_

Operations: \_\_\_\_\_

Family History: (especially breast, ovarian, colon cancer or blood clots) \_\_\_\_\_

Past Medical History: Breast, ovarian, or colon cancer, TB, Heart disease, Diabetes, German measles or Rubella, Anemia, Blood Clots, Thrombophlebitis, Liver disease, Asthma, Bleeding disorders, Stomach ulcers, Kidney disease or stones, Cystitis, Rheumatic fever, Thyroid disease, Epilepsy, bone fractures, blood transfusions, Nervous or Mental Problems, Positive HIV or AIDS: \_\_\_\_\_

OB/GYN History: Married: \_\_\_\_\_ yrs. Spouse: Health \_\_\_\_\_ Age: \_\_\_\_\_

Do you feel threatened at home either physically or verbally? \_\_\_\_\_

Age of first menses: \_\_\_\_\_ Y.O. Cycle: \_\_\_\_\_ days Duration: \_\_\_\_\_ days Flow: \_\_\_\_\_

Symptoms: \_\_\_\_\_

Complications of pregnancy or infertility problems (Toxemia, UTI, RH, C-section, large baby (over 9 lbs.)) \_\_\_\_\_

Number of pregnancies: \_\_\_\_\_

Number of Premature Children: \_\_\_\_\_

Number of miscarriages: \_\_\_\_\_

Number of Living Children: \_\_\_\_\_

Number of stillborns: \_\_\_\_\_

Last Pap smear: Date: \_\_\_\_\_

Result: \_\_\_\_\_

History of abnormal smears: \_\_\_\_\_

Last mammogram: Date: \_\_\_\_\_

Result: \_\_\_\_\_

History of:

Heavy or Prolonged Periods: \_\_\_\_\_

Abdominal Pain: \_\_\_\_\_

Vag. discharge or itching: \_\_\_\_\_

Pelvic Infection: \_\_\_\_\_

Venereal disease: \_\_\_\_\_

Loss of urine: \_\_\_\_\_

Vulva lesion: \_\_\_\_\_

Breast masses or discharge: \_\_\_\_\_

DES exposure in mother: \_\_\_\_\_

Uterine enlargement of fibroids: \_\_\_\_\_

Ovarian cysts: \_\_\_\_\_

Bladder or kidney infection: \_\_\_\_\_

Bleeding after intercourse: \_\_\_\_\_

Other: \_\_\_\_\_

Birth Control:

Types: \_\_\_\_\_ Duration of RX \_\_\_\_\_ Side effects \_\_\_\_\_

\_\_\_\_\_ or problems: \_\_\_\_\_

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FOR OFFICE USE ONLY:

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Hematocrit: \_\_\_\_\_ BP: \_\_\_\_\_

Urine: \_\_\_\_\_ Micro: \_\_\_\_\_ Culture: \_\_\_\_\_

PROTEIN

SUGAR

LMP: \_\_\_\_\_