HEALTH HISTORY QUESTIONNAIRE

Name *(Last, First, M.I.)*:	☐ M ☐ F	**DOB:**	**AGE:**
Reason for visit:		**Occupation:**	

PERSONAL HEALTH HISTORY

List your prescribed drugs and over-the-counter drugs ☐ **None**

Name of medication	Strength/Frequency	Start Date	Condition treating

Allergies to medications ☐ **None**

Name the Drug	Reaction You Had

Over the counter supplements, vitamins and herbal supplements:

PAST HEALTH HISTORY

Have you ever had: check if yes.

- ☐ Cancer When? ___________ what type?______________________
- ☐ Sexually transmitted disease(s) What type?____________________
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Blood clot(s)
- ☐ Diabetes
- ☐ Asthma
- ☐ Thyroid
- ☐ Bleeding disorder
- ☐ Other:____

PRESENT HEALTH HISTORY

Check all current medical problems or concerns:

- ☐ Digestion or bowel
- ☐ Bladder or urinary
- ☐ Heart/chest pain/high blood pressure
- ☐ Heart murmur/palpitations
- ☐ Lungs/breathing
- ☐ Thyroid
- ☐ Diabetes/blood sugar
- ☐ Bleeding disorder or history of blood clot or embolization
- ☐ Cancer: What type? ____
- ☐ Mood disorder/depression
- ☐ Incontinence
- ☐ Other: ____

FAMILY HISTORY

- ☐ Adopted
- ☐ Cancer Who? __________________________Type_______________
- ☐ Bleeding disorder
- ☐ Heart disease
- ☐ Osteoporosis
- ☐ Other:____

PAST SURGERIES

Year	Operation	Surgeon	Complications

Do you smoke?	☐ Yes	☐ No	how much?______________________________quit?___________
Do you drink alcohol?	☐ Yes	☐ No	how much?______________________________quit?___________
Do you use recreational/illicit drugs?	☐ Yes	☐ No	how much?______________________________quit?___________
Are you recovering from substance abuse?	☐ Yes	☐ No	

PREGNANCIES

No	Year	type of delivery, miscarriage or abortion
1.		
2.		
3.		
4.		
5.		
6.		
7.		

MENSTRUAL HISTORY

Age first started:

Timing of menses (# of days from 1st day to 1st day of next menses):

Duration of bleeding(# of days):

Pain (circle one): NONE MILD SEVERE

Bleeding in between menses? ☐ Yes ☐ No

Spotting or bleeding with intercourse? ☐ Yes ☐ No

Painful intercourse? ☐ Yes ☐ No

History of sexual abuse? ☐ Yes ☐ No

Total # of sexual partners? __________Male Female

Do you do a monthly self breast exam? ☐ Yes ☐ No

Date of your last period?

Date of your last mammogram?

Date of your last pap smear? Abnormal Pap? ☐ Yes ☐ No

Current method of birth control?

Does anyone hit, hurt or frighten you? ☐ Yes ☐ No

Do you have any problem with sexual function? ☐ Yes ☐ No