HEALTH QUESTIONNAIRE

This questionnaire is part of your medical record and is kept confidential. It will not be released to any other person without your written consent.

Name:_____ Age:_____ Date:_____

Birthplace:_____ Religion (optional):_____

Date of last examination:_____

Family practice doctor or internist:_____

Last mammogram:_____ ( ) None

REASON FOR TODAY'S VISIT: _____

_____

MENSTRUAL HISTORY:
Date of last period (First day): _____

Any abnormal bleeding: _____

Severe menstrual cramps: _____ PMS: _____

Other pelvic pain: _____

Vaginal infections: _____

History of gonorrhea: _____

PID (Pelvic inflammatory disease): _____ Condyloma (Genital warts): _____Herpes:_____

Any abnormal Pap smears: _____

Any history of domestic violence, physical or sexual abuse, rape or incest: _____

CURRENT CONTRACEPTION: Type: _____ None: ( ) Inactive: ( )
PREVIOUS PREGNANCIES: None: ( )
List all pregnancies (include miscarriages, abortions, ectopics and stillborn)

YEAR	LENGTH OF PREGNANCY	C-SECTION	SEX	BABY'S WEIGHT	COMPLICATIONS
1.					
2.					
3.					

PLEASE CIRCLE ANY SIGNIFICANT MEDICAL PROBLEMS YOU HAVE OR HAVE HAD:

SEVERE HEADACHES
SWELLING OF HANDS OR FEET
ABDOMINAL PAIN
DEPRESSION
ASTHMA OR OTHER LUNG PROBLEMS
DIABETES
LUMPS IN THE BREAST
DISCHARGE FROM NIPPLES
CANCER
KIDNEY PROBLEMS
HEPATITIS
BLADDER INFECTIONS
LOSE URINE WHEN COUGH OR LAUGH
HIGH BLOOD PRESSURE
INTESTINAL PROBLEMS
ENVIRONMENTAL ALLERGIES
EMOTIONAL DISORDER
PHLEBITIS (CLOTS IN VEINS)
BLOOD DISORDER
SYPHILIS
SERIOUS INJURY
TUBERCULOSIS
HEMORRHOIDS
HEART PROBLEMS
DES EXPOSURE
THYROID DISEASE
TRANSFUSIONS
EPILEPSY
OTHER: _____

MEDICATION ALLERGIES: None: ( )

Penicillin: _____ Tetracycline: _____ Sulfa: _____
Other: _____

CURRENT MEDICATIONS: None: ( )

Hormones: _____ Thyroid: _____ Birth control pills: _____
Aspirin or Ibuprofen: _____ Insulin:_____ Diuretics (water pills): _____
Other: _____

SURGERY None: ( )

	YEAR		YEAR		YEAR
Hysterectomy:	_____	C-Section:	_____	Tonsils:	_____
Ovaries:	_____	D&C:	_____	Appendix:	_____
Tubes:	_____	Breast:	_____	Gall Bladder:	_____

Other: _____
Complications: _____

OTHER HOSPITALIZATIONS: _____

HABITS: None: ( )

	AMOUNT	AMOUNT	AMOUNT	AMOUNT
Coffee or cola:	_____	Alcohol:_____	Tobacco: _____	Drugs: _____

DISEASES IN BLOOD RELATIVES: (Who?)

Breast Cancer: _____ Pelvic Cancer: (uterus, ovaries):_____

Other: _____