HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	**Recent weight:**
Previous or referring provider:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Reason for your visit or any current/recent problems:

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No

List your prescribed medication and over-the-counter meds, such as vitamins and supplements

Name the Medications	Strength	Frequency Taken

Allergies to medications

Name the Medication	Reaction You Had

WOMEN HEALTH HISTORY

Age at onset of menstruation: Date of last menstruation: Period every _____ days

Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Are you pregnant or breastfeeding? Circle one if answered yes	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean or uterine procedure or surgery?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No

Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap smear: / / Any Abnormal? Yes/No Date of Mammogram: / / Any Abnormal? Yes/No		

PREGNANCY SUMMARY

Total Pregnancies	Full term	Premature	Elective Abortion	Miscarriages	Ectopic Pregnancies	Multiple Birth	Total Living

PREGNANCY DETAILS

DATE	WEEKS	HRS IN LABOR	WEIGHT	SEX	TYPE	ANESTHESIA (Epidural/IV/General /Local/None)	Complications (Vaccum, forceps, VBAC, etc.)	Place of Birth	Preterm Labor
				M/F	Vag/ CS				Y/N
				M/F	Vag/ CS				Y/N
				M/F	Vag/ CS				Y/N
				M/F	Vag/ CS				Y/N
				M/F	Vag/ CS				Y/N
				M/F	Vag/ CS				Y/N
				M/F	Vag/ CS				Y/N

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)				
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	If yes, what kind?				
	How many drinks per week?				
	Are you concerned about the amount you drink?			☐ Yes	☐ No
	Have you considered stopping?			☐ Yes	☐ No
	Have you ever experienced blackouts?			☐ Yes	☐ No
	Are you prone to "binge" drinking?			☐ Yes	☐ No
	Do you drive after drinking?			☐ Yes	☐ No
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit			
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes	☐ No
Sex	Are you sexually active?			☐ Yes	☐ No
	Partners: Female / Male / Both	How many current partners:			
	If yes, are you trying for a pregnancy?			☐ Yes	☐ No

	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any history of STD's? (Chlamydia/ Gonorrhea/ Herpes/ HIV/ Syphillis/ Hep C) if yes circle one	☐ Yes	☐ No
	Any discomfort with sexual activity?	☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	☐ Yes	☐ No
Personal Safety	Any Physical abuse at home? (ex, hit, kicked, pushed or have been forced to do anything against your will)	☐ Yes	☐ No
	Any Emotional abuse at home? (ex, yelling, manipulation, or isolation)	☐ Yes	☐ No

EMOTIONAL HEALTH		
Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Are you currently seeing a therapist?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	