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.):*	**DATE**	**AGE:**
Reason for visit		

PERSONAL HEALTH HISTORY

MEDICAL PROBLEMS:

OPERATIONS

Year	SURGERY	Reason for Surgery

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had

Please circle one:	**Single**	**Married**	**Separated**	**Divorced**	**Widowed**

OCCUPATION:

HEALTH HABITS AND PERSONAL SAFETY

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

Alcohol	Do you drink alcohol?	☐ Yes	☐ No
	How many drinks per week?		
Tobacco	Do you use tobacco?	☐ Yes	☐ No
	☐ Cigarettes – pks./day		
	☐ # of years	☐ Or year quit	
Drugs	Do you currently use recreational or street drugs?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**SIBLINGS**	☐ M ☐ F	
Mother				☐ M ☐ F	

GYNECOLOGY HISTORY

Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days	Length of period _____ days.	
Number of pregnancies _____	Number of live births _____	
Any hot flashes or sweating at night?	☐ Yes	☐ No
Experienced any recent breast lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap smear:		
Any abnormal pap smears?	☐ Yes	☐ No
Date of Last Mammogram:	Results:	
Any History of Sexually Transmitted Diseases?	☐ Yes	☐ No
Date of Last Colonoscopy:		

OTHER PROBLEMS

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

☐ Weight gain	☐ Nausea/Vomiting	☐ Painful Intercourse
☐ Weight loss	☐ Constipation	☐ Breast Pain
☐ Fever	☐ Blood in Urine	☐ Vaginal Discharge
☐ Fatigue	☐ Pain with Urination	☐ Depression
☐ Frequent Diarrhea	☐ Urinary Urgency	☐ Wheezing
☐ Bloody Stools	☐ Abnormal Periods	☐ Shortness of Breathe (SOB)
☐ Vision Changes	☐ Frequent Bruises	☐ Rash
☐ Ear Aches	☐ Allergies (Hay Fever)	☐ Ulcers
☐ Sinus Problems	☐ Allergies (Seasonal)	☐ Dizziness
☐ Sore Throat	☐ Dry Skin	☐ Seizures
☐ Painful Breathing	☐ Abnormal Thirst	☐ Other pain/discomfort:
☐ Chest Pain	☐ Spitting/Coughing up Blood	☐ Other
☐ Difficult Breathing on Exertion	☐ Heart Palpitations	☐ Muscle Weakness
☐ Swelling of Legs	☐ Persistent Cough	☐