

Original Date:
Dates Revised:

HEALTH HISTORY QUESTIONNAIRE - FEMALE

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

Name <i>(Last, First, M.I.):</i>	<input type="checkbox"/> M <input checked="" type="checkbox"/> F	DOB:
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Previous or referring doctor:	Date of last physical exam:	

PERSONAL HEALTH HISTORY

Childhood illness:	<input type="checkbox"/> Measles	<input type="checkbox"/> Mumps	<input type="checkbox"/> Rubella	<input type="checkbox"/> Chickenpox	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Polio
Immunizations and dates:	<input type="checkbox"/> Tetanus		<input type="checkbox"/> Pneumonia			
	<input type="checkbox"/> Hepatitis		<input type="checkbox"/> Chickenpox			
	<input type="checkbox"/> Influenza		<input type="checkbox"/> MMR <i>Measles, Mumps, Rubella</i>			

List any medical problems that other doctors have diagnosed

Surgeries		
Year	Reason	Hospital

Other hospitalizations		
Year	Reason	Hospital

Are your immunization up to date (current)? Please Bring records.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had a blood transfusion?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please turn to next page

List the primary pharmacies used over the last two years (24 months): (Use back page if more than two were used)

Pharmacy 1: name:		Phone number	()
Street address:	City:	State:	ZIP Code:
Dates from:		To:	
Pharmacy 2: name:		Phone number	()
Street address:	City:	State:	ZIP Code:
Dates from:		To:	

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

HEALTH HABITS AND PERSONAL SAFETY

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

Exercise	<input type="checkbox"/> Sedentary (No exercise)		
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)		
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
Diet	Are you dieting?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	# of meals you eat in an average day?		
	Rank salt intake	<input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low	
	Rank fat intake	<input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low	
Caffeine	<input type="checkbox"/> None <input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Cola		
	# of cups/cans per day?		
Alcohol	Do you drink alcohol?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what kind?		
	How many drinks per week?		
	Are you concerned about the amount you drink?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you considered stopping?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever experienced blackouts?		<input type="checkbox"/> Yes <input type="checkbox"/> No

	Are you prone to "binge" drinking?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you drive after drinking?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tobacco	Do you use tobacco?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit	
Drugs	Do you currently use recreational or street drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sex	Are you sexually active?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you trying for a pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Personal Safety	Do you live alone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have frequent falls?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have vision or hearing loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have an Advance Directive and/or Living Will?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Would you like information on the preparation of these?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Children	<input type="checkbox"/> M	
Mother				<input type="checkbox"/> F	
Sibling	<input type="checkbox"/> M			<input type="checkbox"/> M	
	<input type="checkbox"/> F		<input type="checkbox"/> F		
	<input type="checkbox"/> M		<input type="checkbox"/> M		
	<input type="checkbox"/> F		<input type="checkbox"/> F		
	<input type="checkbox"/> M		<input type="checkbox"/> M		
	<input type="checkbox"/> F		<input type="checkbox"/> F		
	<input type="checkbox"/> M		Grandmother		
	<input type="checkbox"/> F		<i>Maternal</i>		
<input type="checkbox"/> M		Grandfather			
<input type="checkbox"/> F		<i>Maternal</i>			
<input type="checkbox"/> M		Grandmother			
<input type="checkbox"/> F		<i>Paternal</i>			
<input type="checkbox"/> M		Grandfather			
<input type="checkbox"/> F		<i>Paternal</i>			

MENTAL HEALTH

Is stress a major problem for you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you panic when stressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have problems with eating or your appetite?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you cry frequently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever attempted suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever seriously thought about hurting yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Do you have trouble sleeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been to a counselor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
GENITAL ORGANS		

Age at onset of menstruation:		
Date of last menstruation:		
Period every ____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Number of pregnancies	Number of live births	
Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a D&C, hysterectomy, or Cesarean?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any urinary tract, bladder, or kidney infections within the last year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any problems with control of urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any hot flashes or sweating at night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Experienced any recent breast tenderness, lumps, or nipple discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last pap and rectal exam?		

OTHER PROBLEMS

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

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Weight
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy level
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	<input type="checkbox"/> Other pain/discomfort:
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	

Disclosure:
Please provide the most current and complete information in this history questionnaire. This information is used solely by the physician and staff for the purpose of determining your medical needs and services. The information will assist in assessing if any exceptional or specialized services may be required, and how it can be best delivered to each unique patient and her medical needs.