DATE

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.):*	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Why are you here today? Reason for visit?	
Were you referred? ☐ Yes ☐ No Provider Name:	**Last physical exam date?**
Name(s) and addresses of doctors to whom we send reports:	

MEDICATIONS-PLEASE INCLUDE ALL VITAMIN AND SUPPLEMENTS
If you have a medication list please give it to the front desk

Name, Dosage, Frequency	

Are you allergic to any medications? ☐ YES ☐ NO If yes, fill out below:

	Reaction You Had

PERSONAL HEALTH HISTORY

Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Shingles
	☐ Influenza	☐

PREGNANCIES AND GYNECOLOGIC HISTORY		
How many times have you been pregnant _____ Number of vaginal deliveries _____ Number of C-sections _____ Miscarriages___ Abortions induced_____ Abortions spontaneous _____ Ectopic pregnancy _____ Multiple births _____ Living _____		
Delivery complications (large tears, rectal trauma, bladder injuries) KEEP		
When did your most recent period start?: Date_____ or **Age at menopause**_____ Date of last pap and/or rectal exam? _____		
Do/did you have regular cycles? ☐ Yes ☐ No Cycles are/were (circle) Heavy/Normal/Light		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Do you/Did you use a method to prevent pregnancy?	☐ Yes	☐ No
Circle methods used: Pills, Diaphragm, Condom, Depo-provera, IUD, Foam and Jelly, Rhythm, Vasectomy, Tubal ligation		
Pap history: Any abnormal pap smears?	☐ Yes	☐ No
If yes, circle any treatments: Colposcopy Biopsy LEEP Cone biopsy Laser Freezing/Cryosurgery		
When was your last mammogram? DATE:		
Have you ever had an abnormal mammogram?	☐ Yes	☐ No
If yes, explain:		
STD history: (please circle all that apply) HPV Chlamydia Gonorrhea Syphilis Trichomonas Herpes		
Do you currently have a sexual partner? ☐ Male ☐ Female ☐ Both		
Do you always use condoms? ☐ Yes ☐ No		
Do you have pain or other problems with intercourse? ☐ Yes ☐ No		
Have you ever taken hormone replacement?	☐ Yes	☐ No
If so, for how long and which type?		

FAMILY HEALTH HISTORY		
	RELATIONSHIP OF FAMILY MEMBER	WHAT TYPE OF DISEASE?
Blood coagulation disorder		
Stroke		
Dementia		
Diabetes		
Disorder of thyroid		
Endometrial cancer		
Endometriosis		
Heart disease		
High cholesterol		
High blood pressure		
Skin cancer, melanoma		
Uterine cancer, melanoma		

Breast cancer, malignant		
Cervical cancer, malignant		
Colon cancer		
Lung cancer		
Ovarian cancer		
Cancer of pancreas		
Other cancer not listed		
Osteoporosis		
Other hereditary disease not listed		

SOCIAL HISTORY
Tobacco use: ☐ never ☐ current ☐ former smoker, how long?
Exercise level: ☐ none ☐ occasional ☐ moderate ☐ heavy
Marital status: ☐ single ☐ married ☐ divorced ☐ widowed ☐ separated ☐ domestic partner
Diet: ☐ regular ☐ vegetarian ☐ vegan ☐ gluten free ☐ carbohydrate ☐ cardiac ☐ diabetic
Alcohol intake : ☐ none ☐ occasional ☐ moderate ☐ heavy
Caffeine intake: ☐ none ☐ occasional ☐ moderate ☐ heavy
Do you use illicit drugs? ☐ yes ☐ no

	Do you have a health care surrogate/advocate?	☐ Yes	☐ No
		☐ Yes	☐ No
	Do you have an advanced directive or living will?	☐ Yes	☐ No
	Deaf or impaired hearing?	☐ Yes	☐ No
	Blind or impaired vision?	☐ Yes	☐ No
	Difficulty concentrating, remembering or decision making?	☐ Yes	☐ No
	Difficulty walking or climbing stairs?	☐ Yes	☐ No
	Difficulty dressing or bathing?	☐ Yes	☐ No
	Difficulty doing errands alone?	☐ Yes	☐ No
	History of domestic violence?	☐ Yes	☐ No
		☐ Yes	☐ No
	Will you accept a blood transfusion in an emergency?	☐ Yes	☐ No
		☐ Yes	☐ No

UROGYNECOLOGIC SURGERY HISTORY

Please check any surgeries you have had:				
☐ Urethral dilation/stretching	☐ Urethral bulking	☐ Botox in Bladder	☐ Interstim Implant	☐ Fistula repair
☐ Hydrodistension (cysto)	☐ Radical surgery (cancer)	☐ Pelvic radiation (cancer)	☐	☐
☐ Repair of injury to ureter	☐ Repair of injury to bladder	☐ Urethral diverticulum	☐	☐
☐	☐	☐	☐	☐
Prolapse surgery for dropped organs (circle one) Abdominal /Large Incision Vaginal Laparoscopic/Robotic Was mesh used ? ☐ Yes ☐ No ☐ Not sure				
Incontinence surgery for urine leakage (circle one) Abdominal /Large Incision Vaginal: Synthetic mesh sling or Biologic Tissue sling? Laparoscopic/Robotic				
Repair of Rectal Prolapse (tissue coming out through anus) (circle one) Abdominal /Large Incision Vaginal/transrectal Laparoscopic/Robotic Was any intestine removed ? ☐ Yes ☐ No				

Please add any other pelvic surgery not listed here

SURGICAL HISTORY

☐ Abdominal surgery	☐ Bartholin's Gland surgery		☐ Colposcopy	☐ Cryotherapy (freezing) of the cervix
☐ Cystoscopy (bladder)	☐ D&C	☐ Ectopic pregnancy surgery	☐ Endometrial ablation	☐ Endometrial biopsy
☐ Fibroid surgery (myomectomy)	☐ Hysterectomy	☐ Hysteroscopy (Uterus)	☐ Labial Abscess	☐ Laparoscopy
☐ LEEP/Cone biopsy	☐ Ovarian surgery		☐ Removal of both ovaries	☐ Removal of one ovary L/R
☐ Tubal ligation	☐ Tubal reversal		☐ Vulvar surgery	☐ Cerclage
☐ Caesarian section	☐ Breast biopsy	☐ Breast lumpectomy for benign lump	☐ Breast implants	☐ Breast lumpectomy for CANCER
☐ Breast mastectomy	☐ Breast reconstruction	☐ Breast reduction	☐ Cancer surgery (specify)	☐ Heart surgery (specify)
	☐ Skin surgery	☐ Parathyroid surgery	☐ Thyroid surgery	☐ Adenoid/tonsil surgery
☐ Cataract surgery	☐ Other eye surgery (specify)	☐ Abdominal surgery (specify)	☐ Appendectomy	☐ Gall bladder surgery (cholecystectomy)
☐ Colon surgery	☐ Colonoscopy	☐ Hemorrhoid surgery	☐ Hernia repair	☐ Liver biopsy
☐ Splenectomy	☐ Weight loss surgery	☐ Back surgery (specify)	☐ Brain surgery (specify)	☐ Joint replacement
☐ Knee surgery	☐ Cosmetic surgery	☐ Kidney stones surgery	☐ Other orthopedic surgery	☐ Pacemaker
	☐	☐	☐	☐

Please add any other surgery not listed here or add detail information to above

PAST MEDICAL HISTORY

Please check if you have, or have had, any of these conditions:				
Cancer:				
☐ Bladder cancer	☐ Breast cancer	☐ Cervical cancer	☐ Uterine (endometrial) cancer	☐ Colon cancer
☐ Vaginal or vulvar cancer	☐ Other cancer (explain)	☐ Ovarian cancer	☐ Skin cancer	☐ Pulmonary embolus (clot in lung)
☐ Cervical cancer	☐ Diabetes (any form)	☐ Stroke	☐ Heart attack	☐ High cholesterol
☐ Overactive thyroid (hyperthyroid)	☐ Underactive thyroid (hypothyroid)	☐ Kidney stones	☐ Kidney disease (other)	☐ Osteoporosis
☐ Glaucoma	☐ Macular degeneration	☐ GERD or gastritis	☐ Irritable bowel syndrome	☐ Liver disease
☐ Gallstones	☐ Fibromyalgia	☐ Lupus	☐ Rheumatoid arthritis	☐ Sjogrens Disease
☐ Endometriosis	☐ Interstitial cystitis	☐ Migraine headaches	☐ Depression	☐ Bipolar disorder
☐ Recurrent urinary tract infections	☐ Hepatitis	☐ Tuberculosis	☐ HIV/AIDS	☐ Head injury/seizures
☐ Chronic back pain	☐ Anemia	☐ Arthritis	☐ Asthma	☐ Atrial fibrillation
☐ Blood clots (DVT)	☐	☐ Thyroid cancer	☐ Hypertension (high blood pressure)	

Please add any other illnesses not listed here or explain where necessary:

REVIEW OF SYSTEMS

Check any symptoms you currently have or have recently had:

☐ Fever	☐ Chills	☐ Fatigue
☐ Change in appetite	☐ Unusual weight gain	☐ Unusual weight loss
☐ Vision changes	☐ Eye pain	☐ Mouth pain/sores
☐ Hearing loss	☐ Ear pain	☐ Ringing in ears
☐ Persistent sore throat/pain swallowing	☐ Nosebleeds	☐ Dental pain or other problems
☐ Coughing or wheezing	☐ Productive cough (sputum)	☐ Shortness of breath
☐ Coughing up blood	☐ Chest pain with exertion	☐ Palpitations
☐ Swelling in arms or legs	☐ Varicose veins	☐ Shortness of breath when lying down
☐ Breast masses	☐ Breast tenderness	☐ Changes in skin on breasts
☐ Nipple discharge	☐ Abdominal pain	☐ Nausea or vomiting
☐ Constipation	☐ Bloating	☐ Diarrhea
☐ Heartburn	☐ Changes in bowel movements	☐ Rectal bleeding
☐ Accidental bowel leakage	☐ Urinary urgency	☐ Frequent urination
☐ Painful urination	☐ Flank pain	☐ Pelvic pain
☐ Blood in urine	☐ Urination while sleeping	☐ Trouble initiating urinary stream
☐ Involuntary loss of urine	☐ Incomplete emptying of bladder	☐ Vaginal discharge
☐ Vaginal odor	☐ Vaginal itching or burning	☐ Vaginal lesions
☐ Vaginal protrusion	☐ Postmenopausal bleeding	☐ Changes in thirst
☐ Changes in appetite	☐ Cold or heat intolerance	☐ Abnormal menses
☐ Abnormal menstrual flow	☐ Painful periods	☐ PMS symptoms
☐ Menopausal symptoms	☐ Sexual problems	☐ Muscle aches
☐ Muscle weakness	☐ Joint pain	☐ Back pain
☐ Headaches	☐ Dizziness	☐ Numbness
☐ Memory loss	☐ Seizures	☐ Tingling
☐ Loss of consciousness	☐ Impaired concentration	☐ Swollen glands
☐ Easily bruised	☐ Excessive bleeding	☐ Rashes
☐ Abnormal moles	☐ Abnormal hair pattern	☐ Skin itching
☐ Signs of depression	☐ Anxiety problems	☐ Excess irritability
☐ Abnormal sleep patterns	☐ Substance abuse	☐ Suicidal thoughts
☐ Wish to harm others	☐ Skin itching	☐ Hives
☐ Excess sneezing	☐ Excess watery eyes	☐ Excess runny noes