Patient's Name: _____

Please Print

Health Questionnaire

Note that your provider uses this information to treat you.
Please provide the most accurate and complete information possible.

1. Please indicate the reason for today's visit: ☐ Routine check-up ☐ Pain ☐ Bleeding ☐ Contraceptive advice ☐ Infertility ☐ Other _____
2. Do you have any physical concerns you would like to discuss at today's visit? _____
3. Do you have any questions to discuss with your provider at today's visit? _____
4. Do you have an Advanced Directive (Living Will)? ☐ Yes ☐ No

OBSTETRICAL HISTORY:

1. How many times have you been pregnant? _____
2. Number of living children? _____
3. How many of your deliveries were Vaginal deliveries? _____
4. How many were C/Section? _____
5. Did you have any pregnancy complications? yes / no Please explain: _____

MEDICAL HISTORY:

1. Date of your last Pap test: _____
2. Date of your last Mammogram: _____

3. Do you currently take any Medications on a regular basis? (including aspirin, vitamins or over the counter medications)

Medication	Dose

4. Do you have any Allergies?

To Medications: _____

To Other: _____

5. Are you currently being treated for any medical problems? ☐ Yes ☐ No
   If yes, please explain: _____
6. When was your last immunization for:

Rubella	Tetanus	Influenza	Pneumoccoccal Pneumonia	Hepatitis B
Date _____	Date _____	Date _____	Date _____	Date _____

SURGICAL HISTORY (Please list all previous surgeries):

Operation	Date

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

Please Print Patient's Name: _____

FAMILY HISTORY:

In your family, is there a history of:

1. Cancer yes no _____
2. High Blood Pressure yes no _____
3. Diabetes yes no _____
4. Heart Disease yes no _____
5. Osteoporosis yes no _____
6. High Cholesterol yes no _____
7. Other _____
8. Family

	Year of Birth	Major Illness	Cause of Death
Father			
Mother			
Brothers and Sisters			

SOCIAL HISTORY:

1. Single / Married / Widowed / Divorced
2. Do you smoke? yes no (# of cigarettes per day _____)
3. Do you drink alcohol on a regular basis? yes no (# of drinks per week _____)
4. Do you currently use any street drugs? yes no
5. Is there any history of physical, sexual, or emotional abuse? yes no
6. Do you have any history of sexually transmitted disease? yes no
   (syphilis, gonorrhea, herpes, chlamydia, or genital warts)

MENSTRUAL HISTORY:

1. When was the first day of your last menstrual period? _____
2. How many days apart are your periods? _____
3. How many days does the flow last? _____
4. Are your periods regular? yes / no
5. How old were you when you first began having your period? _____
6. Do you have painful periods or cramps? yes / no (explain) _____
7. What method of birth control do you use? _____
   (birth control pills, condoms, tubal ligation, vasectomy, IUD, rhythm, other)
8. Do you experience any symptoms of PMS? yes / no (explain) _____

ROS:

Do you experience any of the following symptoms (please check all that apply)?

☐ Blurry vision	☐ Black stool	☐ Weakness
☐ Blindness	☐ Leaking of urine	☐ Depression
☐ Chest pain	☐ Blood in your urine	☐ Breast discharge
☐ Shortness of breath	☐ Frequent urge to urinate	☐ Hot flashes
☐ Cough	☐ Frequent night time urination	☐ Bleeding gums
☐ Pain with breathing	☐ Leaking of urine with intercourse	☐ Easy bruising
☐ Constipation	☐ Joint pain	☐ Weight:loss/gain
☐ Diarrhea	☐ Back pain	☐ Fever/chills
☐ Leaking of stool	☐ Frequent headaches	☐ Night sweats
☐ Blood in your stool	☐ Numbness	

To the best of my knowledge, the above information is true and correct: _____
Signature