Health History Questionaire

PLEASE CHECK IF YOU HAVE ANY OF THE FOLLOWING CONDITIONS

___ Breast Cancer ___Stroke ___Osteoporosis

___Ovarian Cancer ___Heart Disease ___Bleeding Disorders

___Uterine Cancer ___High Blood Pressure ___Deep Vein Thrombosis

___Cervical Cancer ___Diabetes ___Blood Transfusions

___Colon Cancer ___Thyroid Disease ___Migraine Headaches

___Other _____

LIST ALL SURGERIES, PROCEDURES AND HOSPITALIZATIONS

YEAR	TYPE	REASON

LIST ALL PRESCRIPTION AND OVER THE COUNTER MEDICATIONS (including vitamins, supplements, inhalers)

NAME	DOSE	FREQUENCY	REASON

LIST ANY ALLERGIES TO FOOD OR MEDICATIONS_____

_____

ALLERGIES TO: ___LATEX ___ADHESIVE TAPE ___XRAY, CT OR MRI DYES ___IODINE

PREFERRED:	NAME	LOCATION AND PHONE#
LOCAL PHARMACY		
MAIL-AWAY PHARMACY		
LABORATORY		
IMAGING CENTER		

GYNECOLOGICAL HISTORY

1. When was the **FIRST** day of your last menstrual period?_____
2. What age did your menstrual period start?_____**yrs** old
3. Are your menstrual periods regular? ___ YES or ___ NO
   If **NO,** menstrual periods start every ____ to ____ days (example 12 to 45 days)
4. How long do your periods last? ____ days
5. How would you describe your menstrual flow? ___light ___moderate ___heavy
6. Do you have cramps with your periods? ___ yes ___no
7. Do you have bleeding in between your periods? ___yes ___no
8. Do you have bleeding after intercourse? ___yes ___no
9. What is your current form of birth control?

___None	___Pills	___Diaphragm	___Essure
___Abstinence	___Patch	___Nexplanon	___Tubal Ligation
___Rhythm	___Vaginal Ring	___Mirena	___Vasectomy
___Condoms	___Depo-Provera	___Paragard	

10. List any form of birth control method that you **DO NOT TOLERATE**._____
11. Are you sexually active? ___yes ___no
12. Have you had any new sexual partners in the last year? ___yes ___no
13. Have you ever had a sexually transmitted infection? ___yes ___no
14. Have you had the Gardasil vaccine? ___yes ___no
15. Age at menopause?_____
16. Have you ever used Hormone Replacement Therapy? ___yes ___no
    (If **YES,** how many years?) _____
17. Have you ever had an **ABNORMAL PAP SMEAR**? ___yes ___no
    (If **YES,** did you have a colposcopy?) ___yes ___no
18. Have you ever had an **ABNORMAL MAMMOGRAM**? ___yes ___no
    (If **YES,** what was the follow up?) ___ultrasound ___surgical referral ___biopsy-result_____

PLEASE PROVIDE DATE AND RESULT OF THE *MOST RECENT* OF THE FOLLOWING TESTS:

	MONTH/YEAR	RESULTS
PAP SMEAR		
HPV TEST		
MAMMOGRAM		
BONE DENSITY		
COLONOSCOPY		

OBSTETRICAL HISTORY

Total Pregnancies_____ Full-Term_____ Pre-Term_____ Miscarriage_____
Ectopic_____ Termination of Pregnancy_____ Multiple Gestations_____ Vaginal Births_____
C-Section_____ Total Live Births_____ **(**twins,triplets,etc**.)**_____

SOCIAL HISTORY

Do you smoke? ___yes ___no If **YES,** how many packs a day? _____
Do you drink alcohol? ___yes ___no If **YES,** how many drinks per week? _____
Do you use illicit drugs? ___yes ___no
What is your marital status? **Single Married Divorced Widow**
What is your sexual orientation? ___ Heterosexual ___ Homosexual ___ Bisexual

FAMILY HISTORY (PLEASE INDICATE **AGE** OF ONSET IN THE APPROPRIATE BOX**)**

	BREAST CANCER	***OVARIAN CANCER***	***UTERINE CANCER***	***COLON CANCER***	***DIABETES***	***BLEEDING DISORDER***	***BLOOD CLOTTING DISORDER***	***THYROID***	***HIGH BLOOD PRESSURE***	***CARDIAC DISEASE***
MOTHER										
FATHER										
BROTHER										
SISTER										
SON										
DAUGHTER										
MATERNAL GM										
MATERNAL GF										
PATERNAL GM										
PATERNAL GF										

PLEASE LIST ALL PHYSICIANS YOU SEE

1. _____ **(PRIMARE CARE PHYSICIAN)**
2. _____ **(GASTROENTEROLOGIST)**
3. _____ **(DERMATOLOGIST)**
4. _____ **(CARDIOLOGIST)**
5. _____ **(SURGEON)**
6. _____ **(0THER)**

_____

SIGNATURE OF PATIENT/GUARDIAN ***TODAY'S DATE***