

Please print, fill out, and bring this page to the office with you.

HEALTH HISTORY QUESTIONNAIRE

Name: (Last, First, M.I.)		<input type="checkbox"/> M <input 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 illnesses:	<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

Other hospitalizations

Have you ever had a blood transfusion? Yes No

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H E A L T H H I S T O R Y Q U E S T I O N N A I R E

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

Allergies to medications	
Name the drug	Reaction you had

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:		