HEALTH QUESTIONNAIRE

NAME: _____ **DATE:** _____

INTERNIST: _____ **REFERRING DR:** _____

Please indicate the main reason for your visit: Pain Irregular bleeding Pregnancy Discharge
Cancer Screening Family Planning Infertility Protruded Organs Sexual Problems
Urinary Symptoms Other _____

Menstruation: Started at age: __ Number of days from start of one period to start of next__
Number of days period lasts: __ Date of last normal menstrual period (1st day) ___
Obstetric history: Number of times you have been pregnant ___ Full term babies __
Abortions _____ Premature___ Miscarriages___ Stillborns___
Ages of children___ _____

PLEASE CIRCLE *YES* OR *NO* OR ANSWER THE QUESTIONS IF THEY PERTAIN TO YOU

Current method of birth control _____

Are your periods irregular	Yes	No	Do you bruise easily	Yes	No
Are your periods painful	Yes	No	Do you vomit after eating	Yes	No
Do you pass clots with your periods	Yes	No	Do you often eat between meals	Yes	No
Do you bleed between periods	Yes	No	Do your ankles swell	Yes	No
Do you bleed after douching or intercourse	Yes	No	Do you have varicose veins	Yes	No
			Do you get short of breath	Yes	No
Do you get tense before periods	Yes	No	Do you faint easily	Yes	No
Do you have any symptoms of pregnancy	Yes	No	Do you get headaches	Yes	No
			Do you get hot flashes	Yes	No
Is it difficult for you to become pregnant	Yes	No	Do you sleep poorly	Yes	No
			Do you wake up tired	Yes	No
Is sexual intercourse painful	Yes	No	Do you cry easily	Yes	No
Any problem with sexual intercourse	Yes	No	Have you ever been treated for nervousness	Yes	No
Are you troubled with a discharge other than blood	Yes	No	Are you dissatisfied with your work	Yes	No
Does this discharge cause itching or irritation	Yes	No	Are you dissatisfied with your family situation	Yes	No
Do you have a history of female problems	Yes	No	Are you in a safe and nurturing relationship	Yes	No
Do you urinate frequently	Yes	No			
Do you have the urge to urinate now	Yes	No	Has a past or present partner caused you physical harm or forced you to do anything you did not want to do	Yes	No
Do you pass blood in your urine	Yes	No			
Do you lose urine when you cough or sneeze	Yes	No			

Have you been operated on in the last 5 years (list operations & dates) Yes No

_____

_____

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Does it feel like anything is pushing out of your vagina	Yes	No	Do you smoke cigarettes	Yes	No
Do you have to push anything up to empty your bowel or bladder	Yes	No	How many times a week do you drink Beer_____ Wine_____ Liquor_____ How many glasses per week do you drink Beer_____ Wine_____ Liquor_____		
Are you constipated	Yes	No			
Do you often have diarrhea	Yes	No	Have you ever felt the need to cut down on your drinking	Yes	No
Do you ever pass blood in your stools	Yes	No			
Do you ever have painful bowel movements	Yes	No	Have you ever had guilty feelings about your drinking	Yes	No
Do you ever have black stools	Yes	No			
Have you gained or lost weight recently	Yes	No	Have you ever felt annoyed by criticism of your drinking	Yes	No
Is your appetite or diet poor	Yes	No			
Do you exercise regularly	Yes	No	Have you ever taken a morning "eye opener"	Yes	No
Have you had any serious injuries	Yes	No			
Have you had any blood transfusions	Yes	No	Do you use marijuana (pot) How often per week_____	Yes	No
Do you drink more than 6 cups of coffee per day	Yes	No	Do you use cocaine (coke) How often per week_____	Yes	No

Are you taking any medication _____

_____

Are you taking any "over the counter" drugs or any herbal or nutritional/health products--please list below

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS AND IF SO PLEASE LIST ***Yes No***

_____

Circle any of the following you have had in the past five years:

Arthritis	Cancer	High Blood Pressure	Lung Problems	Convulsions
Allergies	Diabetes	Kidney Problems	Tuberculosis	
Anemia	Heart Condition	Sexually Transmitted Disease	Jaundice	

Other illness or medical problems: _____
Circle any of the following occurring in your family:

Arthritis	Convulsions	High Blood Pressure	Strokes	Multiple Births
Birth Defects	Diabetes	Mental Illness	Tuberculosis	Heart Disease
Cancer				

Are your parents living Yes No If deceased cause of death _____