HEALTH HISTORY QUESTIONNAIRE

DATE: ______________________

NAME: ____

AGE: __________ MARITAL STATUS: Single / Married / Divorced / Widowed DATE OF BIRTH: ______________________

RELIGIOUS PREFERENCE: ______________________________ RACE: ______________________

Date of last Pap smear: ______________________

Have you ever had an abnormal Pap smear? Yes No

Have you ever had cryosurgery? Yes No
(freezing of the cervix)

How old were you when you first started your period: ______________________

What was the first day of your last normal menstrual period: ______________________

Are your periods: Regular Irregular

Do you often skip periods? Yes No

Do you have heavy bleeding with your period? Yes No

Do you have pain with your period? Yes No
Mild Moderate Severe

Do you have pain during or after intercourse? Yes No

Are you having any problems with sex? Yes No

Which of the following birth control methods have you used in the past:
Foam/Condoms/Diaphragm/Birth control pill/IUD
Vaginal sponge/Vasectomy/Tubal ligation

Are you currently using birth control? If yes, what type?
____

How many children: ______________

How many miscarriages: ______________

How many abortions: ______________

Are you trying to become pregnant? Yes No

Did your mother take hormones during pregnancy? Yes No
(ie DES, diethylstilbestrol, etc.)

Do you have any history of the following:

Herpes Infection	Yes	No
Tubal/Ovarian Infection	Yes	No
Gonorrhea	Yes	No
Syphilis	Yes	No
Chlamydia	Yes	No
Condyloma (HPV)	Yes	No
Hepatitis	Yes	No
HIV	Yes	No

Do you have cyclic breast pain? Yes No

Do you have a history of breast lumps or tumors? Yes No

Do you have any milk or discharge from your breasts? Yes No

Do you perform self breast examination? Yes No

Do you have a family history of breast cancer? Yes No

Have you ever had a mammogram? Yes No

Do you lose urine when lifting heavy objects or coughing? Yes No

Do you have involuntary loss of urine? Yes No

Do you experience bladder symptoms of urgency, frequency, or pain? Yes No

Do you smoke?
If so, ______________ cigarettes/packs a day.

How much alcohol do you consume weekly?
______________ drinks per week

How many cups of coffee, cokes or glasses of tea do you consume daily? ______________

Are you allergic to any drugs or medications? Yes No
If so, please list them:
____
____
____
____

FAMILY HISTORY

Has any blood relative ever had any of the following: (if yes, please circle)
CANCER, LEUKEMIA, DIABETES, HEART DISEASE, HIGH BLOOD PRESSURE, STROKE, ARTHRITIS

Have you or your husband, or anyone in either of your families, ever had one of the following: (if yes, please circle)
CLEFT LIP/PALATE, DOWNS SYNDROME (MONGOLISM), HEMOPHILIA, MUSCULAR DYSTROPHY, DEFECTS OF THE SPINE (SPINA BIFIDA), HYDROCEPHALUS (WATER ON THE BRAIN), MENTAL RETARDATION, SICKLE CELL DISEASE, STILLBORN BABY, CHROMOSOMAL ABNORMALITIES, INHERITED OR GENETIC DEFECTS, CONGENITAL ABNORMALITIES (i.e., CYSTIC FIBROSIS), BIRTH DEFECTS.

Are there any diseases which tend to run or recur in your family?

If yes, please explain: ____
____
____

(OVER)

REVIEW OF MEDICAL HISTORY

Have you ever experienced any of the following diseases, illnesses, surgical procedures? (If yes, please circle)

Depression	Hepatitis/Yellow jaundice	Bone surgery
Nervous breakdown/Mental Problems	Gallbladder disease/stones	Bladder surgery
Seizure disorder/Convulsions	Kidney disease/stones/infection	C-Section
Concussion/Head injury	Diabetes	Laparoscopy
Migraine Headaches	Arthritis/Bone disease	Hysterectomy
Thyroid problem/Goiter	Broken bones	Removal of ovaries and/or tubes
Asthma	Cancer or leukemia	Surgery of fallopian tubes or ovaries
Emphysema/Bronchitis	Blood transfusions	Cryosurgery or Cervical Cone (LEEP)
Heart problems/Angina	Anemia	D & C
Hypertension/High blood pressure	Tonsillectomy	Treatment of abnormal Pap smear
Heart Murmur	Head/Neck surgery	Abnormal mammogram
Rheumatic fever	Heart/Lung surgery	Breast Surgery (augmentation implants or reduction)
Phlebitis/Thrombophlebitis	Appendectomy	Hysterosalpingogram
Stomach ulcers	Gallbladder surgery	Hysteroscopy
Colitis	Other abdominal surgery	Colposcopy

Have you ever been prescribed fertility medications? If yes, what type? ______

Have you ever had artificial inseminations? ______

If yes, were you given fertility medications at the time? ______ Were sonograms performed to monitor follicular growth? ______

Have you ever had InVitro Fertilization? ______ How many cycles? ______

if yes, what medications did you take? ______ How many eggs were retrieved? ______

How many embryo were transferred to your uterus? ______ Did a pregnancy occur? ______

Do you have cryopreserved embryos? ______ If so, where? ______

List any other medical illnesses or surgical procedures: ______

List all present medications: ______

List all allergies: ______

HEALTH DATA

Date of last pelvic examination: ______

Date of last physical examination: ______

Name of Internal Medicine Specialist/Family Doctor: ______

Briefly describe your current problem: ______

DATE: ______ PATIENT'S SIGNATURE: ______