HEALTH QUESTIONNAIRE FOR OBSTETRICS AND GYNECOLOGY DATE____________________

The purpose for having you fill out this questionnaire is to obtain an accurate health history. The information obtained in this questionnaire is kept confidential and will not be released except when you have authorized us to do so.
Before filling out the questionnaire we would like you to read it thoroughly and then start answering the questions. For any health problem that had occurred previously it is important to list the year it occurred. Symptoms, problems or questions not marked or answered will be considered not applicable. If you can't remember, or if you don't understand the meaning of a question, indicate this with a question mark.

NAME____ AGE_______ REFERRED BY________________________

What is your chief complaint, main problem or reason why you want to be seen:
____
____
____
____
____
____

MENSTRUAL HISTORY:
Last menstrual period (date or age)_____________________
Was last menstrual period of usual amount & duration __ Y __ N
Date of menstrual period previous to last one______________
How many days do your period's last_____________________
How often do you have a period________________________
Flow ___ Light ___ Moderate ___ Heavy ___ Excessive
Pain ___ Light ___ Moderate ___ Heavy ___ Excessive
First menstrual period at the age of______________________

ABNORMAL MENSTRUAL PERIODS For how long______
In regard to___ duration ___ frequency ___ flow ___ pain
Bleeding/Spotting___ before ___ after ___ between periods
___ after intercourse ___ completely irregular bleeding
____
____
____
____
____

In the week prior to your menstrual period, do you experience any of the following symptoms, which at other times, are "Uncommon" or less profound and disappear when your period has started:___ abnormal bloating discomfort ___ swelling of feet, ankles, or face ___ irritability ___ nervousness ___ depression ___ headaches ___ breast tenderness ___ weight gain

VAGINAL DISCHARGE: For how long_______________

Color	**Odor**	**Amount**	**Consistency**	**Symptoms**
__ white	__ none	__ little	__ watery	__ none
__ yellow	__ some	__ moderate	__ thick	__ burning
__ brown	__ bad	__ large	__ mucous	__ itching

How often do you douche:______________________________

What methods of contraception (birth control) do you use:
____
Side effects from the birth control pill (describe):__________
____
____
____

PROBLEMS WITH SEXUAL INTERCOURSE ___YES ___NO
____

PROBLEMS WITH BREASTS For how long____________
___ lumps ___ tenderness ___ secretion of milk
___discharge from nipples

PAIN: (other than menstrual pain) Where:_______________________________________ For how long:___________

Onset	**Intensity**	**Nature**		
__sudden	__severe	__sharp	__burning	__bearing down feeling in pelvic area
__rapid	__mild	__dull	__throbbing	__feeling of heaviness & fullness in the pelvis
__gradually	__moderate	__shooting	__crampy	__feeling like the female organs would drop out

Progression
__constant
__intermittent
__becoming increasingly worse

What makes it worse:____
Does it radiate into other areas of body____________________________________
What relieves it:____
Other symptoms associated with it:_____________________________________

PROBLEMS WITH URINATING: For how long_____________
__ painful __ sudden urge to urinate
__ frequent __ loss of urine with coughing, laughing or walking
__ abnormal color __ unable to empty bladder completely

PROBLEMS WITH BOWEL MOVEMENTS: For how long___
__ diarrhea __ abnormal color of stool
__ constipation __ pain with bowel movements
__ blood in stool __ difficulty emptying the rectum

APPETITE: __ Good __ Poor **WEIGHT:** __ Gain __ Loss How much?____ __ Nausea __ Vomiting How long?______

PROBLEMS WITH: ___ hot flashes ___ Palpitations of heart___ Night sweats For how long?____________________

__ nervous	__ guilt feelings	__ feeling lonely	__ feel like giving up	__ difficulty sleeping
__ irritable	__ trouble remembering things	__ sense of failure	__ feeling hopeless	__ depressed
__ waking up early	__ excessive worry	__ loss of interest in social life	__ marked tiredness	__ crying often
__ loss of sexual interest	__ family problems	__ feeling frightened	__ wanting to be alone	__ loss of energy
__ no ambition	__ thoughts of ending life	__ marital problems	__ difficulty making decisions	

GYNECOLOGICAL HISTORY (list problems with your female organs in the past)

____

____

____________________________________Date of last Pap Smear (cancer smear)____________________________

OBSTETRICAL HISTORY: How many times have you been pregnant:_______________

Full term______ Premature:________ Multiple birth_______ Stillborn:______ Miscarriage______ Now Alive_________

No	M/D/Year	Sex	Wt.	Length Preg.	Length Labor	Problems

Do you think you are pregnant now? __ Y __ N

Are you upset about being pregnant? __ Y __ N

Have you tried to become pregnant and been unsuccessful?___

Were any miscarriages complicated by fever? __ Y __ N

Have any children been released for adoption? __ Y __ N

What is the age of your oldest / youngest child ____ / ____

MEDICATIONS: (list all drugs you are taking now):

____

____

____

ALLERGIES: (if allergic to drugs, list reaction):

____

____

____

DO YOU HAVE NOW (mark X) **or HAVE YOU EVER HAD PROBLEMS** (list year) **WITH**:

__ skin __ lungs __ bladder __ sinus trouble __ High blood pressure __ blood clots

__ sensitivity to cold __ glands __ heart __ bones/joints __ chest pain __ heartburn

__ anemia __ always thirsty __ eyes/vision __ stomach __ muscles __ short of breath

__ leg cramps __ abnormal hair growth __ ears/hearing __ bowels __ back __ cough

__ yellow jaundice __ bleeding tendency __ dizziness __ nose __ liver __ nerves

__ asthma __ hemorrhoids __ thyroid trouble__ light-headed __ teeth __ gallbladder

__ blood __ pneumonia __ arthritis __ diabetes __ fainting spells __ throat

__ kidneys __ arteries, veins __ swollen feet __ varicose veins __ voice change __ objects rotating

__ ulcer

CHANGE IN: __ handwriting __ gait __ speech __ coordination __ balance

Seizures of any kind:________________ __ numbness __ tingling __ other changes in sensation:________________

Severe headache_______________________________Weakness in one arm or leg________________________________

SURGICAL PROCEDURES – **YEAR** **YEAR**

___________________________________ _________ _____________________________________ ________

___________________________________ _________ _____________________________________ ________

___________________________________ _________

___________________________________ _________

___________________________________ _________

SEVERE ACCIDENTS or INJURIES

_____________________________________ ________

_____________________________________ ________

STUDIES – list year __ ECG

X-Ray of:__ chest __ bowel

__ kidney __ gallbladder

OTHER:_________________________

____

infection

____

IMMUNIZATION RECORD: **YEAR**

________________________ ________

________________________ ________

________________________ ________

________________________ ________

________________________ ________

INFECTIOUS DISEASES: - list year

__german measles __hepatitis

__poliomyelitis __parasites/worms

__rheumatic fever __mononucleosis

__tuberculosis __venereal

Other:_________________________

FAMILY HISTORY: Have any of your family been affected by one of the following conditions: If yes, state the relationship (father, mother, etc.)

__ Cancer __ Heart Disease __ Congenital Anomalies __ Diabetes __ Mental disease

__ Bleeding Tendency __ High Blood Pressure __Twins __ Hereditary Disorders

__ Other:____

How do you consider your health in general:

__ Excellent __ Good __ Fair __ Poor

When was your last complete physical and/or gynecologic examination:

____

Have you seen another doctor for your present problem?

(state name):___________________________________

If yes, what was his diagnosis, treatment, recommendation

____

____

____

____

____

SOCIAL HISTORY:

Occupation(s) past and present:______________________

____

____

Education______________________________________

__ single __ married __ widowed __ divorced

Number of years married___ Married more than once___

Alcoholic drinks/how much____ Cigarettes/how many_____

How many hours of sleep___________________________

Do you get time for relaxation, hobbies, exercise?________

Husband/Age_________ Health_________

Occupation_________________________