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Comprehensive Health History Questionnaire

Name____ Today's Date____________
Address____ Date of Birth___________
____ Marital Status M S D W
Phone Home___________________________ Work______________________________

Menstruation

What was your age of menstruation?	Age
Date of last menstruation period?	Date
How long did your period last?	Days
How long is your menstrual cycle?	Days in Cycle
Are your menstrual periods irregular?	**No** **Yes**
Do you use pads or tampons ?	**Pads** **Tampons**
How many do you use on your heaviest day?	

Do You:	Rarely/Never	Occasionally	Frequently
Have any menstrual problem?			
Feel tense just before your period?			
Have heavy menstrual bleeding?			
Have painful menstrual bleeding?			
Have bleeding between periods?			

Other Gynecological

Do You:	Rarely/Never	Occasionally	Frequently
Have breast tenderness?			
What was the date of your last pap test?			**Date:**
Have any discharge from your nipples?			
Have your breast changed in size?			
Examine your breast monthly for lumps?	**Yes**	**No**	
Have you ever had a mammogram?	**Yes**	**No**	**Date:**
Did you breastfeed your children?	**Yes**	**No**	
Have any unusual vaginal burning, itching or discharge?			
Have any problems with or questions about venereal diseases?			
Have hot flashes?			
Have you ever taken Estrogen or other hormones?			

Family Planning and Pregnancy History

1. Methods of birth control
   Currently:
   ☐ Not applicable, partner has had vasectomy or is otherwise sterile.
   ☐Not applicable, I have had a ☐tubal ligation ☐hysterectomy ☐other_____________________
   ☐None ☐IUD ☐Diaphragm ☐Foam ☐Pill (Name_________) ☐ Injection ☐ Other ☐ Condoms
2. Do you have any questions about birth control? **Yes** **No**
3. Do you have any questions or problems concerning sex? **Yes** **No**
4. Do you have pain or discomfort with intercourse? **Yes** **No**
5. Times pregnant?____ Living Children____ Miscarriages___ Abortions___ Premature Births ___
6. How old were you during your first pregnancy? _________________Years Old

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Family Planning and Pregnancy History

No.	Born (month/year)	Weight at Birth	Sex	Length of Pregnancy	Delivery Type	Complications
1.						
2.						
3.						
4.						

Family Planning

Illness	X	Year	Illness	X	Year	Illness	X	Year
Glaucoma			Diverticulosis			Cancer or tumor		
Cataracts			Colitis			Anemia		
			Other bowel			Bleeding Tendency		
			Hepatitis			Blood transfusion		
Deafness			Liver trouble					
Thyroid trouble			Gallbladder					
Strep throat			Hernia			Diabetes		
Bronchitis			Hemorrhoids					
Emphysema			Bladder Disease			Rubella		
Pneumonia			Breast Problems			Polio		
Phlebitis			DES exposure					
Asthma			Kidney Disease			Scarlet fever		
Tuberculosis			Varicose Veins			Mononucleosis		
Lung Problems			Mental Problems			Nervous breakdowns		
Heart Attack			Headaches			High Blood Pressure		
Head injury			Stroke			Condylomata warts		
Heart murmur			Chlamydia			Artherosclerosis		
Convulsions			Seizures			Genital Herpes		
Arthritis			Rheumatic Fever			Other STDs		
Heart condition			Arthritis			AIDS		
Eczema			High cholesterol			Psoriasis		
Ulcers			Gout			Other		

Please list all times you have been hospitalized, operated on, or seriously injured

Year	Operation/Illness/Injury	Hospital and City

Medications

Please list all medications you are now taking, including those you buy without a doctor's prescription (such as vitamins and aspirin)

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Allergies and Sensitivities

List anything that you are allergic to such as certain foods, medications, dust, chemicals, or soaps, household items, pollens, bee stings, and indicates how each affect you.

Allergic To	Effects

Your Family's Health History

Please give the following information about your immediate family:

Relationship	Age if Living	Age at Death	State of Health or Cause of Death
Father			
Mother			
Brother			
Brother			
Sister			
Sister			
Spouse			
Child 1			
Child 2			
Child 3			
Child 4			

Have any blood relatives had any of the following illnesses? If so indicate relationship?

Diabetes	
Asthma	
Emphysema	
Bronchitis	
Tuberculosis	
Cystic Fibrosis	
Blood Disease	
Glaucoma	
Epilepsy	
Rheumatoid Arthritis	
Gout	
Peptic Ulcer	
Gallbladder Disease	
Colitis/Irritable Bowel	
Gynecological Problems	
Obstetrical Problems	
Breast Problems	
Birth defects	
Genetic abnormalities	
Migraine headaches	
Mental Problems	

Current General health, attitude, and habits.

How is your overall health now? ☐Poor ☐Fair ☐Good ☐Excellent

How has it been most of your life? ☐Poor ☐Fair ☐Good ☐Excellent

In the past year

Has your appetite changed? ☐Decreased ☐Increased ☐Stayed the same

Has your weight changed? Lost _____ lbs Gained_____ lbs No change_____

Are you thirsty much of the time? **No** **Yes**

Has your overall "pep" changed? ☐Decreased ☐Increased ☐Stayed the same

Do you usually have trouble sleeping? **No** **Yes**

How much do you exercise? ☐Little or none ☐Less than I need ☐More than I need

Do you smoke? **No** **Yes** **# of years _____**

How many each day? Cigarettes_____ Cigars_____ Pipefuls______

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Current General health, attitude, and habits (continued).

Have you ever smoked? **No** **Yes**

Do you drink alcoholic beverages? **No** **Yes**

Average alcoholic beverages per day: ___# Beers ___ #Glasses of Wine ___#Drinks of Hard Liquor

Have you ever had a problem with alcohol? **No** **Yes**

How much coffee or tea do you usually drink? ______ cups of coffee or tea a day

Do You	Rarely/Never	Occasionally	Frequently
Feel nervous?			
Feel depressed?			
Find it hard to make decisions?			
Lose your temper?			
Worry a lot?			
Tire easily?			
Have trouble relaxing?			
Have any sexual problems?			
Nauseated?			
Stomach pains?			
Burps after eating?			
Heartburn?			
Trouble swallowing food?			
Vomit blood?			
Constipated?			
Diarrhea?			
Painful bowel movements?			
Bloody bowel movements?			
Dark bowel movements?			
Date of last sigmoidoscopy?			
Ever feel like committing suicide?			
Feel bored with your life?			
Use marijuana?			
Use “hard drugs”			
Sudden urge to urinate?			
Not make it to the bathroom in time?			
Urinate 8 or more times per 24 hours?			
Urinate 2 or more times a night?			
How long have you had these symptoms?	____ **# years**		
Hard to start urine flow?			
Painful urinations?			
Urine dark color or bloody?			
Lose urine: strain, laugh, cough, sneeze			
Lose urine: sleep			
Do you want to talk to the Dr. about a personal problem?	**Yes**	**No**	

Additional comments:

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Thank you for completing this questionnaire. Please review for skipped questions, sign your name on the space to the right and return it to the physician or assistant. If you wish to add any information, please write it on the spaces provided.

____

Patient signature and date