JACKSON HEALTHCARE FOR WOMEN

Health History Questionnaire: 2021

CHART NO. _____ TODAY'S DATE: _____

Name: _____ DOB: _____ Age: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Reason for Visit: ☐ Wellness Exam **OR** ☐ Problem: _____

Referring Physician: _____

Address: _____

Email Address: _____

Home Phone: _____ Work Phone: _____ Cell: _____

PLEASE NOTE: FOLLOW-UP OR ADDITIONAL OFFICE VISITS AT A LATER TIME MAY BE NECESSARY TO ADDRESS MEDICAL AND/OR GYNECOLOGICAL PROBLEMS.

MENSTRUAL HISTORY *(COMPLETE EVEN IF POST-MENOPAUSAL OR NO LONGER HAVING PERIODS.)*

Age of first period: _____ years.

If your menstrual periods are regular: periods start every _____ days.

If your menstrual periods are irregular: periods start every _____ to _____ days. (e.g., 12 to 60 days)

Duration of bleeding with each menstrual period: _____ days.

Does bleeding or spotting occur between periods? ☐ Yes ☐ No

Does bleeding or spotting occur after intercourse? ☐ Yes ☐ No

First day of last menstrual period: _____

Is pain associated with periods? ☐ Yes ☐ No ☐ Occasionally ☐ Mild ☐ Moderate ☐ Severe

If yes, is it: ☐ Before menses ☐ During menses ☐ Both

Current birth control: _____

Tubal Ligation ☐ Yes Vasectomy ☐ Yes

PREGNANCY HISTORY

☐ Never been pregnant

Number of pregnancies: _____

Number of miscarriages: _____

Number of abortions: _____

Number of vaginal deliveries: _____

Number of cesarean deliveries: _____

Number of living children: _____

Are you currently breastfeeding? ☐ Yes ☐ No

SEXUAL HISTORY

☐ I am not sexually active.

☐ I am sexually active with one partner. ☐ Male ☐ Female

☐ I am sexually active with more than one partner. How many? _____ ☐ Male ☐ Female ☐ Both

What age did you become sexually active? _____

Do you have any sexual problems that you would like to discuss? ☐ Yes ☐ No If yes, what? _____

_____

SOCIAL HISTORY

Smoking: ☐ Never ☐ Former ☐ Yes: Packs/Day _____, Years smoked _____ ☐ Cigarettes ☐ VAPE ☐ Marijuana

Alcohol: ☐ Never ☐ Former ☐ Yes: ☐ 2 or less drinks/day, ☐ 3+ drinks per day Type _____

Illicit Drugs: ☐ Never ☐ Former ☐ Current Use Type _____

Caffeine Intake: ☐ Yes ☐ No / ☐ Coffee ☐ Tea ☐ Soda ☐ Energy Drink ☐ Chocolate / Daily Intake _____

Regular Exercise: ☐ Yes ☐ No Days/Week _____ Hours/Day _____

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OB/GYN SURGICAL HISTORY *(CHECK ANY THAT APPLY. INDICATE YEAR OF SURGERY.)*

- ☐ None
- ☐ Ablation _____
- ☐ D&C _____
- ☐ Essure _____
- ☐ Hysteroscopy _____
- ☐ Infertility surgery _____
- ☐ Tuboplasty _____
- ☐ Tubal ligation _____
- ☐ Laparoscopy _____
- ☐ Hysterectomy (vaginal) _____
- ☐ Hysterectomy (abdominal) _____
- ☐ Hysterectomy (robotic) _____
- ☐ Myomectomy _____
- ☐ Ovarian surgery _____
- ☐ L ovarian cyst(s) removed _____
- ☐ R ovarian cyst(s) removed _____
- ☐ L ovary removed _____
- ☐ R ovary removed _____
- ☐ Vaginal or bladder support procedure for prolapse or incontinence _____
- ☐ Cesarean section _____
- ☐ Other (specify) _____

OTHER SURGICAL HISTORY *(CHECK ANY THAT APPLY. INDICATE YEAR OF SURGERY.)*

- ☐ None
- ☐ Appendectomy _____
- ☐ Gallbladder _____
- ☐ Mastectomy R | L | Both _____
- ☐ Tonsillectomy _____
- ☐ Adenoids _____
- ☐ Thyroidectomy _____
- ☐ Other (specify) _____

PAP SMEAR/MAMMOGRAM HISTORY/BONE DENSITY/COLONOSCOPY

Date of last pap smear: _____ Have you had abnormal pap smears? ☐ Yes ☐ No

Have you had treatment for abnormal smears? ☐ Yes ☐ No If yes, what type(s) of treatment have you had? Include year of procedure. ☐ Cryotherapy _____ ☐ Laser _____ ☐ Cone biopsy _____ ☐ Loop excision (LEEP) _____

Date of last mammogram _____ Have you had an abnormal mammogram? ☐ Yes ☐ No

Date of last bone density _____ Date of last colonoscopy _____

OTHER GYNECOLOGICAL HISTORY *(CHECK ANY THAT APPLY.)*

- ☐ None
- ☐ Venereal warts
- ☐ Herpes – genital
- ☐ Syphilis
- ☐ Pelvic inflammatory disease
- ☐ Endometriosis
- ☐ Chlamydia
- ☐ Gonorrhea
- ☐ Vaginal infections
- ☐ Trichomoniasis
- ☐ HIV
- ☐ HPV
- ☐ Other (specify) _____

FAMILY HISTORY *(CHECK ANY THAT APPLY.)*

Mother: ☐ Living ☐ Deceased – Cause _____

Father: ☐ Living ☐ Deceased – Cause _____

Sibling(s): Number of Living _____ Number Deceased _____ Cause(s) of death: _____

Which of your family members have or had the following? Indicate age if condition resulted in death.

	Affected Relative *(Father, Mother, Brother, Sister, Son, Daughter)*
☐ None	
☐ Diabetes	
☐ Ovarian Cancer	
☐ Heart Disease	
☐ Endometrial Cancer	
☐ Breast Cancer	
☐ Colon Cancer	
☐ High Blood Pressure	
☐ High Cholesterol	
☐ Stroke	
☐ Osteoporosis	
☐ Other (specify)	

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YOUR MEDICAL HISTORY *(CHECK ANY THAT APPLY.)*

- ☐ None
- ☐ Arthritis
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Breast Cancer
- ☐ Kidney Disease
- ☐ Gallstones
- ☐ Liver Disease, includes hepatitis
- ☐ Epilepsy
- ☐ Eating Disorder
- ☐ Heart Disease
- ☐ Blood Clots Leg/Thigh
- ☐ Asthma
- ☐ Migraines
- ☐ Hemorrhoids
- ☐ HIV+
- ☐ Blood Transfusions
- ☐ Thyroid Disease
- ☐ Irritable Bowel Syndrome
- ☐ Anxiety
- ☐ Depression
- ☐ Fibromyalgia
- ☐ Cancer (specify) _____

Injuries and accidents: _____

CURRENT MEDICATIONS *(INCLUDE DOSE/AMOUNT PER DAY)*

_____ _____

_____ _____

_____ _____

Preferred Pharmacy: _____ Phone: _____

Pharmacy Address: _____

DRUG ALLERGIES

☐ Yes ☐ No If Yes, list drug allergies: _____

Latex Allergy? ☐ Yes ☐ No

REVIEW OF SYMPTOMS *(CHECK ANY THAT APPLY WITHIN THE LAST THREE MONTHS.)*

MENOPAUSE SYMPTOMS
- ☐ Y ☐ N Hot flashes
  How often? _____
- ☐ Y ☐ N Vaginal dryness
- ☐ Y ☐ N Mood swings
- ☐ Y ☐ N Trouble sleeping

CONSTITUTIONAL
- ☐ Y ☐ N Fatigue
- ☐ Y ☐ N Weight loss
- ☐ Y ☐ N Weight gain
- ☐ Y ☐ N Menopausal concerns

CARDIOVASCULAR
- ☐ Y ☐ N Shortness of breath
- ☐ Y ☐ N Chest pain
- ☐ Y ☐ N Irregular heart beat
- ☐ Y ☐ N Swelling in legs or feet

PULMONARY
- ☐ Y ☐ N Wheezing
- ☐ Y ☐ N Cough
- ☐ Y ☐ N Coughing up anything

BREAST
- ☐ Y ☐ N Breast pain
- ☐ Y ☐ N Nipple discharge
- ☐ Y ☐ N Nipple retraction
- ☐ Y ☐ N Breast Lump

GASTROINTESTINAL TRACT
- ☐ Y ☐ N Constipation
- ☐ Y ☐ N Diarrhea
- ☐ Y ☐ N Blood in stool
- ☐ Y ☐ N Persistent gas
- ☐ Y ☐ N Abdominal pain
- ☐ Y ☐ N Nausea

GENITOURINARY SYSTEM
- ☐ Y ☐ N Blood in urine
- ☐ Y ☐ N Urinary urgency
- ☐ Y ☐ N Painful urination
- ☐ Y ☐ N Urinary frequency
- ☐ Y ☐ N Urinary leakage
- ☐ Y ☐ N Bladder incontinence
- ☐ Y ☐ N Cramps
- ☐ Y ☐ N Irregular cycles
- ☐ Y ☐ N Abn vag bleeding
- ☐ Y ☐ N Vaginal odor
- ☐ Y ☐ N Vaginal itching
- ☐ Y ☐ N Vaginal lesion
- ☐ Y ☐ N Vaginal discharge
- ☐ Y ☐ N Painful intercourse

NEUROLOGICAL
- ☐ Y ☐ N Dizziness
- ☐ Y ☐ N Headache
- ☐ Y ☐ N Numbness

PSYCHOLOGICAL
- ☐ Y ☐ N Depression
- ☐ Y ☐ N Excessive crying
- ☐ Y ☐ N Anxiety

HEMATOLOGICAL SYSTEM
- ☐ Y ☐ N Anemia
- ☐ Y ☐ N Easy bleeding
- ☐ Y ☐ N Easy bruising

SKIN
- ☐ Y ☐ N Lesion

MUSCULOSKELETAL
- ☐ Y ☐ N Weakness

ALLERGIC/IMMUNOLOGIC
- ☐ Y ☐ N Coughing/sneezing
- ☐ Y ☐ N Sinus pain/congestion

Signature _____ Print Name _____ Today's Date _____