



# Health History Questionnaire: 2023

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.)

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

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

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> None               | <input type="checkbox"/> Mastectomy R   L   Both _____ | <input type="checkbox"/> Thyroidectomy _____   |
| <input type="checkbox"/> Appendectomy _____ | <input type="checkbox"/> Tonsillectomy _____           | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Gallbladder _____  | <input type="checkbox"/> Adenoids _____                | _____  |

**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.)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> None                        | <input type="checkbox"/> Endometriosis      | <input type="checkbox"/> HIV                   |
| <input type="checkbox"/> Venereal warts              | <input type="checkbox"/> Chlamydia          | <input type="checkbox"/> HPV                   |
| <input type="checkbox"/> Herpes – genital            | <input type="checkbox"/> Gonorrhea          | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Syphilis                    | <input type="checkbox"/> Vaginal infections | _____  |
| <input type="checkbox"/> Pelvic inflammatory disease | <input type="checkbox"/> Trichomoniasis     | _____  |

**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.

- | <input type="checkbox"/> None                | <b>Affected Relative</b> (Father, Mother, Brother, Sister, Son, Daughter) |
|--|---|
| <input type="checkbox"/> Diabetes            | _____   |
| <input type="checkbox"/> Ovarian Cancer      | _____   |
| <input type="checkbox"/> Heart Disease       | _____   |
| <input type="checkbox"/> Endometrial Cancer  | _____   |
| <input type="checkbox"/> Breast Cancer       | _____   |
| <input type="checkbox"/> Colon Cancer        | _____   |
| <input type="checkbox"/> High Blood Pressure | _____   |
| <input type="checkbox"/> High Cholesterol    | _____   |
| <input type="checkbox"/> Stroke              | _____   |
| <input type="checkbox"/> Osteoporosis        | _____   |
| <input type="checkbox"/> 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 \_\_\_\_\_