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Confidential Health History Questionnaire

Name: ______________________________ **DOB:** ____________

Nickname? ______________________________ **Today's Date:** ____________

Email: ______________________ **Preferred Language:** ______________

Religion: ______________________ **Country of Origin:** ______________

Marital Status: ___Divorced ___Dom. Partner ___Married ___Separated ___Sig. Other ___Single ___Widow ___Other

Race: ___American Indian ___Asian ___Black/African American ___Hispanic/Latino ___Native Hawaiian/Pacific Islander ___White/Caucasian ___Other ___Unknown ___Declined **Ethnicity:** ___ Hispanic/Latino ___Non-Hispanic

Employment Status: ___Full ___Part ___Self ___Unemployed ___Retired ___Military **Student:** ___Full ___Part

Women's Health History, Section I: (If you are menopausal, skip to section II)

At what age did you began having menstrual periods? __________ Are your periods painful? ____ Yes ____ No

How long is the time between 1st day of a period to 1st day of the next period? ________ days

How long do your periods last? ________ days

Do you use birth control? ____ Yes ____ No If so, what type? ______________________

List any other methods used in the past: ______________________________

Are you satisfied with your current form of birth control? ____ Yes ____ No

If you have children, do you desire to have more? ____ Yes ____ No ____ Undecided

Have you had difficulty becoming pregnant? ____ Yes ____ No

Women's Health History, Section II:

Are you menopausal? ____ Yes ____ No Age of menopause? __________

Are you sexually active at this time? ____ Yes ____ No If so, with: ____ Men ____ Women ____ Both

Do you have more than one sexual partner? ____ Yes ____ No Number of sexual partners in the past year: ______

Do you have pain with sex? ____ Yes ____ No Bleeding with intercourse? ____ Yes ____ No

Name: ____ DOB: ___________________ Date: ___________________

Have you ever had Pelvic Inflammatory Disease (PID) or infection in your tubes or ovaries? ____ Yes ____ No

Would you like to be tested for sexually transmitted disease (STD)? ____ Yes ____ No

Have you ever had: ____ Genital Herpes ____ Warts ____ Chlamydia ____ Gonorrhea ____ Syphilis ____ HIV

Have you ever been tested for STDs? ____ Yes ____ No If so, what type and when? __________________________

If so, have you had unprotected intercourse with a new partner since last tested? ____ Yes ____ No

Have you ever been a victim of: ____ Sexual Assault ____ Physical Abuse

____ Domestic Violence (hit, kicked, pushed, threatened, in any way?) Are you currently safe? ____ Yes ____ No

Is there any aspect of your sexuality or sexual problems that you would like to discuss? ____ Yes ____ No

Have you had any of the following vaccines?

____ HPV vaccine? (Age 9-26) ____ Tdap ____ Meningococcal (MCV)

____ Zovirax (Shingles) ____ Flu ____ Pneumococcal (Pneumonia, >65)

Do you have any of the following symptoms:

Vaginal: ____ Odor ____ Burning ____ Itching ____ Bulging ____ Unusual Discharge

Urinary: ____ Pain ____ Frequency ____ Urgency ____ Leaking with cough, laugh, sneeze or exercise

____ Leaking with urgency to urinate ____ Unable to initiate stream/empty completely

Pelvic: ____ Pain ____ Pressure ____ Bloating ____ Uterus, bladder or rectum pushing down

Menopause: ____ Insomnia ____ Hot Flashes ____ Night Sweats ____ Irritability

____ Vaginal Dryness ____ Decreased Sex Drive

Bowels: ____ Hard Stools ____ Blood in Stool

Painful bowel movements? ____ Yes ____ No Frequency of bowel movements? _______________________

Mood: ____ Depression ____ Anxiety ____ Mania ____ Panic Disorder

Do you currently have thoughts of harming yourself or others? ____ Yes ____ No

When was your last Pap smear? _____________________________________ Was it abnormal? ____ Yes ____ No

If yes, please list the year, abnormal result and the follow-up treatment: ____________________________________

____

When and where was your last:

Cholesterol Check: ____ Normal or Elevated? ____________

Mammogram: ____

Colonoscopy: ____

Bone Density Study (DEXA Scan): ____

Name: ____ DOB: ____________________ Date: ____________________

Do you have any allergies? ____

Past/Present Illnesses: (circle all that apply) **Date Diagnosed/Details**:

Diabetes: Type I Type II ____
Headaches: Tension Migraine Unsure ____
Heart Attack or Stroke ____
High Blood Pressure (Hypertension) ____
High Cholesterol or Triglycerides ____
Depression Anxiety Bipolar Disorder ____
Anorexia, Bulimia or other eating disorder ____
Hypothyroidism Hyperthyroidism ____
Cancer: Type__________________________ ____
Asthma or other Lung Disease ____
Recurrent Bladder and/or Kidney Infections ____
HIV Hepatitis B Hepatitis C ____
Bleeding or Clotting Disorder ____
History of Blood Transfusions ____
Pulmonary Embolism, Deep Vein Thrombosis ____
(blood clot in arms, legs or lungs)

Please list any other medical problems, along with details: ____

____

Previous Hospitalizations, Surgeries or Serious Injuries:

Type/Details Year

____ ________________

____ ________________

____ ________________

Personal Habits:

How many times per week do you exercise? _________ What type? ____

Do you smoke/use: ____ Cigarettes ____ eCigarettes/Vapor ____ Marijuana (any form) ____ Smokeless Tobacco

If so, how much/many per day? __________ How long? ____

If you quit smoking, please list when: ____

Do you drink alcohol? ____ Yes ____ No If so, how many drinks per week? ________________________________

If you quit drinking, please list when: ____

Do you drink caffeine? ____ Yes ____ No If so, how much per day? ______________________________________

Have you ever used: ____ Cocaine ____ Heroin/Narcotics ____ Methamphetamines ____ Ecstasy

If so, please list when and how much: ____

Please list any specific questions you wish to discuss with the Doctor: ____

____

Name: ______________________________ DOB: ______________ Date: ______________

Pregnancy History:

How many times have you been pregnant? ________ Number of living children: ______________

Do you have any adopted children? ____ Yes ____ No How many? ______________

Do you have step-children? ____ Yes ____ No How many? ______________

Have you ever had a miscarriage? ____ Yes ____ No Dates: ______________

If so, was a D&C required? ____ Yes ____ No Were there any complications? ____ Yes ____ No

Have you ever had an ectopic (tubal) pregnancy? ____ Yes ____ No When? ______________

If so, were you treated with medication or surgery? ____________ Type? ______________

Were there any complications? ____ Yes ____ No If so, type? ______________

Have you ever had an abortion? ____ Yes ____ No When? ______________

If so, was it medical or surgical? ______________ Were there any complications? ____ Yes ____ No

Previous Births:

Date	Vaginal or Cesarean	Sex	Name	Weight	Complications

Family History – Past/Present Illnesses:

Disease/Condition	Relation	Maternal/ Paternal	Details
Diabetes: Type I Type II			
Heart Disease or Attack			
High Blood Pressure			
High Cholesterol/Triglycerides			
Hypo/Hyperthyroidism			
Breast Cancer			
Uterine Cancer			
Ovarian Cancer			
Other Cancer(s)			
Osteoporosis or Hip Fracture			
Depression or Substance Abuse			
Bleeding or Clotting Disorder			
Pulmonary Embolism, Deep Vein Thrombosis (blood clot in arms, legs or lungs)			

If born between 1938 – 1971, did your mother take DES while she was pregnant with you? ____ Yes ____ No