

# HEALTH QUESTIONNAIRE

Name: \_\_\_\_\_

Birth Date, Age: \_\_\_\_\_

Birthplace: \_\_\_\_\_

Occupation: \_\_\_\_\_

Marital Status: S M DP D W SEP

Please List Any Major Medical Illnesses:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Please List All Current Medications:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Please List All Past Surgeries: (What, When)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Allergies: \_\_\_\_\_

Cigarettes \_\_\_\_\_ packs per day

Alcohol: \_\_\_\_\_ drinks per week

Drug Use: \_\_\_\_\_

### Menstrual History

Age at Onset: \_\_\_\_\_

Cycle Length: \_\_\_\_\_

Duration of Flow: \_\_\_\_\_

Regular: YES NO

Pain / Cramps: YES NO

1<sup>st</sup> Day of Last Period \_\_\_\_\_

Current Birth Control Method: \_\_\_\_\_

### Pregnancy History

Never Been Pregnant

Have Been Pregnant (List All Pregnancies)

Year	Delivery, Miscarriage or Abortion	Sex	Weight	Complications
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

### Past Medical History

	Y	N		Y	N		Y	N
Abnormal Pap Smear	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Bowel Disease	<input type="checkbox"/>	<input type="checkbox"/>
Genital Warts (HPV)	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer / Stomach Problems	<input type="checkbox"/>	<input type="checkbox"/>
Gonorrhea	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Rectal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Syphilis	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Infection / Stones	<input type="checkbox"/>	<input type="checkbox"/>
Chlamydia	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Urine with Cough	<input type="checkbox"/>	<input type="checkbox"/>
Pelvic Inflammatory Disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease / Attack	<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>
HIV / AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy / Neurological Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Infertility	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Migraines / Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Uterine Anomaly	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain / Angina	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>
D.E.S. Exposure	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis / Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Blood clots in Legs/Lungs	<input type="checkbox"/>	<input type="checkbox"/>	Head Injury	<input type="checkbox"/>	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of Hands / Feet	<input type="checkbox"/>	<input type="checkbox"/>	Major Accident	<input type="checkbox"/>	<input type="checkbox"/>
Rubella	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	History of Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Skin Disease	<input type="checkbox"/>	<input type="checkbox"/>	Anesthetic Complications	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever / Lupus	<input type="checkbox"/>	<input type="checkbox"/>	Gall Bladder Disease	<input type="checkbox"/>	<input type="checkbox"/>	Von Willebrand's/Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>

### Family History

	Age	Overall Health	Age	Cause of Death	
Father	_____	_____	_____	_____	Please circle then list which relative has had any of the following: Breast Cancer _____ Ovarian Cancer _____ Uterine Cancer _____ Other Cancer _____ Diabetes _____ Heart Trouble _____ Stroke _____ Epilepsy/Convulsion _____ Tuberculosis _____ Hepatitis _____ Mental Illness _____ Osteoporosis _____
Mother	_____	_____	_____	_____	
Sibling 1	_____	_____	_____	_____	
Sibling 2	_____	_____	_____	_____	
Sibling 3	_____	_____	_____	_____	
Sibling 4	_____	_____	_____	_____	
Partner	_____	_____	_____	_____	
Child 1	_____	_____	_____	_____	
Child 2	_____	_____	_____	_____	
Child 3	_____	_____	_____	_____	
Child 4	_____	_____	_____	_____	