

DATE: _____

HEALTH QUESTIONNAIRE

Name: _____
 Birthdate: _____ Age: _____
 Birthplace: _____
 Occupation: _____
 Marital Status: S M D W SEP

EMERGENCY CONTACT (Other than sp
 Name: _____
 Address: _____
 Phone: _____
 Relationship: _____

PERSONAL MEDICAL HISTORY

Major Medical 1. _____ Current 1. _____
 Illnesses: 2. _____ Medications: 2. _____
 3. _____ 3. _____
 Surgery: 1. _____ 4. _____
 (What, When) 2. _____ Allergies: _____
 3. _____ Cigarettes: _____ (packs/day)
 4. _____ Alcohol: _____ (drinks/week) Drug Use: _____

MENSTRUAL HISTORY:

LIST ALL PREGNANCIES

NEVER PREGNANT

Age at onset: _____	Year	Delivery, miscarriage or abortion	Sex	Weight	Complications (e.g. preterm, C-section)
Cycle length: _____	_____	_____	_____	_____	_____
Duration of flow: _____	_____	_____	_____	_____	_____
Regular: Yes No	_____	_____	_____	_____	_____
Flow: Light Mod Heavy	_____	_____	_____	_____	_____
Pain/Cramps: Yes No	_____	_____	_____	_____	_____

1st day of last period: _____ Current birth control method: _____

PAST MEDICAL HISTORY

	Yes	No		Yes	No		Yes	No
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/heart 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/Neurologic 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 (low blood count)	<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"/>	Gallbladder disease	<input type="checkbox"/>	<input type="checkbox"/>	Von Willebrand's/Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>

FAMILY HISTORY

	LIVING		DECEASED		Has any relative had:	Who?	
	Age	Health	Age	Cause		Yes	No
Father	_____	_____	_____	_____	Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Mother	_____	_____	_____	_____	Ovarian Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Siblings 1	_____	_____	_____	_____	Uterine Cancer	<input type="checkbox"/>	<input type="checkbox"/>
2	_____	_____	_____	_____	Other Cancer	<input type="checkbox"/>	<input type="checkbox"/>
3	_____	_____	_____	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
4	_____	_____	_____	_____	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Partner	_____	_____	_____	_____	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Children 1	_____	_____	_____	_____	Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>
2	_____	_____	_____	_____	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
3	_____	_____	_____	_____	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
4	_____	_____	_____	_____	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>
					Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>