Care for Women's Medical Group, Inc.

Date of Visit:
Dates Revised:

PLEASE FILL OUT FORM PRIOR TO YOUR VISIT

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring doctor:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio		
Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

Reason for visit

Surgeries

Year	Reason	Hospital

Other hospitalizations other than pregnancy/delivery

Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No

Please turn to next page

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to “binge” drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day		
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No

Sex	Are you sexually active?	☐ Yes	☐ No
	If yes, are you trying for a pregnancy?	☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	☐ Yes	☐ No
Personal Safety	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

ENTER "D" FOR DECEASED

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

PERSONAL PAST HISTORY

☐ Fibroids	☐ Heart Disease	☐ Broken Bones
☐ Sexually Transmitted Diseases	☐ High Blood Pressure	☐ Thyroid Disease
☐ Asthma	☐ Stroke	☐ Diabetes
☐ Pneumonia	☐ Rheumatic Fever	☐ Hepatitis
☐ Kidney Stones	☐ Blood Clots (legs/Lungs)	☐ Broken Bones
☐ Infertility	☐ Eating Disorder	☐ Bowel Problems
☐ Reflux	☐ Lupus	☐ Chicken Pox
☐ Anemia	☐ Cancer	☐ HIV

GYNECOLOGIC HISTORY

Age at onset of menstruation:		
Date of last menstruation:		
Period every days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Length of periods days		
Any changes in your periods?	☐ Yes	☐ No
Have you had a hysterectomy?	☐ Yes	☐ No
Have you had a D&C??	☐ Yes	☐ No
Number of lifetime sexual partners		
Present birth control method		
Do you do self breast examinations?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Have you ever had an abnormal pap smear?	☐ Yes	☐ No

DATE OF LAST PAP EXAM?

OBSTETRICAL HISTORY

NUMBER OF PREGNANCIES **NUMBER OF MISCARRIAGES**

No	BIRTH DATE	WEIGHT AT BIRTH	BABY'S SEX	TYPE OF DELIVERY	COMPLICATIONS
1.					
2.					
3.					
4.					

NUMBER OF LIVING CHILDREN **NUMBER OF ABORTIONS**

REVIEW OF SYSTEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

CONSTITUTIONAL	EYES	SKIN
☐ Weight loss	☐ Glasses/Contacts	☐ Rash
☐ Weight Gain	☐ Earaches	☐ Sores
☐ Fever	☐ Ringing in Ears	☐ Moles
☐ Fatigue	☐ Double Vision	☐ Dry Skin
RESPIRATORY	**CARDIOVASCULAR**	**GASTROINTESTINAL**
☐ Painful Breathing	☐ Chest Pain or Pressure	☐ Frequent Diarrhea
☐ Wheezing	☐ Difficulty Breathing with Exertion	☐ Bloody Stool

☐ Spitting up Blood	☐ Swelling of Legs	☐ Nausea/Vomiting
☐ Shortness of Breath	☐ Rapid Heartbeat	☐ Constipation
☐ Chronic Cough	☐ Irregular Heartbeat	☐ Involuntary Loss of Stool/Gas
ENDOCRINE	**GENITOURINARY**	**GENITOURINARY (CONTINUED)**
☐ Hair Loss	☐ Blood in Urine	☐ Incontinence (coughing/sneezing)
☐ Heat Intolerance	☐ Pain with Urination	☐ Abnormal Vaginal Discharge
☐ Cold Intolerance	☐ Urgency	☐ Abnormal Bleeding
☐ Abnormal Thirst	☐ Frequent Urination	☐ Painful Periods
☐ Hot Flashes	☐ Incomplete Emptying	☐ Painful Intercourse
MUSCULOSKELETAL	**HEMATOLOGIC**	**PSYCHIATRIC**
☐ Joint Pain	☐ Frequent Bruises	☐ Post-partum Depression
☐ Muscle Pain	☐ Cuts do not stop bleeding	☐ Anxiety
☐ Muscle Weakness	☐ Enlarged Lymph Glands	☐ Depression
BREASTS	**NEUROLOGICAL**	**NEUROLOGIC (CONTINUED)**
☐ Pain in Breasts	☐ Dizziness	☐ Trouble Walking
☐ Nipple Discharge	☐ Seizures	☐ Memory Problems
☐ Lumps	☐ Numbness	☐ Frequent Headaches
PLEASE DESCIBE ANY PARTICULAR ISSUE THAT YOU WOULD LIKE TO BE ADDRESSED IN MORE DETAIL AT YOUR VISIT		