HEALTH HISTORY QUESTIONNAIRE

NAME____ Age______ DOB___/___/___ Date___/___/___
Referred by:_______________________________
Reason for today's visit____
____

Past Medical History:

List hospitalizations with date:	List serious illness with date:
___________________________________	___________________________________
___________________________________	___________________________________
___________________________________	___________________________________
___________________________________	___________________________________
___________________________________	___________________________________
___________________________________	___________________________________

List the medications you are on; including dosage and number of times per day you take them.
____
____
____

List any DRUG ALLERGIES:____
____
Do you exercise?____
Are you taking Calcium?____
Name any other physician you are seeing____
Name any therapist you are seeing____
Please check any of the following conditions that you have or have had in the past:

__Eye problems	__Anorexia	__Seizures
__Ear problems	__Stomach problems	__Bleeding disorder
__Thyroid disease	__Hepatitis/Liver disease	__Anemia
__Lung problems	__Bowel problems	__Sexually Transmitted Disease
__High Blood Pressure	__Gall bladder disease	__Genital Warts
__Heart disease	__Headache/Migraine	__Immune disorder
__High Cholesterol	__Fainting	__Other________________
__Cancer	__Head injury	
__Diabetes	__Stroke	

Cigarettes: Do you smoke now?_____# per day?_____
Did you ever smoke?_____How long?_____How much?_____When did you quit?_____
Alcohol: Do you drink alcohol?_____# per day?_____What do you drink?_____
Are you an alcoholic?_____Are you in recovery?_____How many years?_____
Family History: Have parents, siblings, grandparents, aunts or uncles had any of the following? Please check if yes and state relationship.

__Diabetes__________________________	__High Blood Pressure_________________
__Asthma___________________________	__Heart Disease______________________
__Cancer___________________________	__High Cholesterol____________________
__Blood Disease_____________________	__Stroke____________________________
__Epilepsy__________________________	__Mental illness______________________
__Rheumatoid Arthritis________________	__Suicide____________________________
__Tuberculosis_______________________	__Alcoholism_________________________
__Osteoporosis______________________	

Mother's age if living_____and general health__________. If deceased, age at death_____Cause________________
Father's age if living_____and general health__________. If deceased, age at death_____Cause________________
List siblings age and health status:____
____
Names of children, age and health status:____
____ Do any children live with you?________________________

Date of last Pap Smear:________________________
Any abnormal Paps in past?____________________
Date of last mammogram:______________________
Any abnormal mammograms?__________________
Do you do monthly self-breast exam?_____________
Date of last Bone density:______________________
Has a close relative had Ovarian or Breast cancer?
____
Date of last period:__________________________
Are periods regular?__________________________
# of days between periods:____________________
Is the flow heavy, average, of light?______________
How long does flow last?______________________
Do you spot or bleed between periods?___________
Are cramps absent, light, moderate, or severe?
____

What, if any symptoms of PMS do you have?
____
Are you a DES daughter?______________________
Do you have abnormal discharge?________________
Do you have pain with intercourse?______________
Have you had any STD's?_____PID?____________
What Birth Control are you using?________________
Do you leak urine?___________________________
Painful or frequent urination?___________________
Do you have frequent bladder infections?__________
# of pregnancies:_____# live births:______________
miscarrages:_____# abortions:_________________
Age at first period:____________________________
If you're postmenopausal, age at last period:_______

Signature____

NEW PATIENT-HISTORY REVIEW & HPI

CC:

HPI:

Additional PMH, Social and Fam. Hx:

Clinician Signature___________________________________