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HEALTH QUESTIONNAIRE

Name: _____ Age: _____ Date: _____

Marital Status: Single Married Separated Widowed Divorced

A. Medical Illnesses (check(✓) below if you have had any of the following)

Childhood Illnesses

- Chicken Pox
- Measles
- Mumps
- Rubella (German Measles)
- Rheumatic Fever
- Birth Abnormalities

Cardiovascular

- Heart Disease
- Heart Murmur
- High Blood Pressure
- Chest Pain
- Swelling Hands and Feet
- Palpitation
- Irregular Heartbeat
- Stroke
- High Cholesterol

Respiratory

- Lung Disease
- Asthma or Wheezing
- Chronic Cough
- Cough with Blood
- Difficulty Breathing
- Pneumonia
- Bronchitis
- Tuberculosis

Gastrointestinal

- Intestinal Disease
- Gallbladder Disease
- Peptic Ulcer
- Liver Trouble
- Hepatitis
- Frequent Constipation
- Frequent Diarrhea
- Black Stools

- Blood in Stools
- Hemorrhoids
- Change in Bowel Habit
- Heartburn
- Abdominal Pain
- Vomiting

Hematologic

- Blood Disease
- Abnormal Bleeding
- Anemia
- Phlebitis
- Easy Bruising
- Sickle Cell Disease
- Blood Transfusion

Genitourinary

- Kidney Trouble
- Kidney Stones
- Loss of Urine

- Frequent Urination
- Nighttime Urination
- Painful Urination
- Blood in Urine

Endocrine

- Thyroid Disease
- Diabetes
- Heat/Cold Intolerance
- Weight Loss
- Difficulty Swallowing
- Recent Wght Change

Skin

- Skin Disease
- Jaundice
- Change/Skin Moles
- Glasses
- Eye Disease

- Glaucoma
- Headaches
- Difficulty Hearing

Musculoskeletal

- Varicose Veins
- Joint Pains
- Back Pain
- Broken Bones
- Arthritis

Neuro-psychiatric

- Psychiatric Care
- Depression
- Convulsions
- Seizures
- Freq. Headaches

B. Surgical History (list type of surgery and year performed)

	Date		Date
1.		4.	
2.		5.	
3.		6.	

C. Gynecological History :

Date of Last PAP: _____ Last Pelvic Exam: _____ Last Mammogram: _____

Menstrual History

Age period started _____ Days of flow _____ Cycle length (e.g. 28 days) _____

Are your cycles regular irregular

Amount of bleeding light average heavy

First day of last period _____

Sexual History

Sexually active: Yes No Frequency of Intercourse: _____

Present birth control methods? _____

Previous birth control methods? _____

History high risk sexual contact (with IV drug users, bisexual, hemophiliac, multiple partners, etc.) Yes No

Have you ever had any of the following?

- Abnormal PAP
- DES exposures
- Pelvic infection
- Herpes
- Gonorrhea
- Chlamydia
- Venereal warts
- Syphilis
- Frequent vaginal infections
- Painful periods
- Bleeding between periods
- Pain with intercourse
- Heavy periods
- PMS
- Other Gynecological problems

PLEASE TURN OVER

