HEALTH HISTORY QUESTIONNAIRE

Name:	Date of Birth:

Reason for today's visit? ____________________

Are you currently receiving care from another provider? ☐Yes ☐No If yes, please list below:

____

Are you currently married or living with significant other? ☐Yes ☐No ☐N/A Name:________________

Last Grade Completed:_______________ Religion: ________________ Ethnicity:________________________

Please check to indicate if you have ever had the following conditions:

☐	Anemia	☐	Anxiety	☐	Arthritis
☐	Asthma	☐	Autoimmune Condition	☐	Back Problem
☐	Bladder Infection	☐	Blood Clotting Condition	☐	Blood Transfusion
☐	Breast Cancer	☐	Cancer (Specify:)	☐	Cholesterol (high)
☐	Depression	☐	Dermatitis	☐	Diabetes
☐	Eating Disorder	☐	Endometriosis	☐	Epilepsy
☐	Gallbladder Disorder	☐	Gastrointestinal Disorder	☐	GERD
☐	Headache	☐	Heart Attack	☐	Heart Condition
☐	Hepatitis	☐	Hypertension	☐	Migraine
☐	Ovarian Cyst(s)	☐	PCOS	☐	Pneumonia
☐	Renal Stone	☐	Rheumatic Fever	☐	STIs (Specify:)
☐	Stroke	☐	TB	☐	Thyroid Condition
☐	Ulcer	☐	Other:		

SURGERIES/ HOSPITALIZATIONS (Ex. Breast Augmentation; Wisdom Teeth):

YEAR	REASON	HOSPITAL

LIST PRESCRIPTIONS/SUPPLEMENTS:

NAME OF DRUG	DOSAGE	FREQUENCY TAKEN

Preferred Pharmacy:

MEDICATION ALLERGIES:

NAME OF THE DRUG	ALLERGIC REACTION (S)

IMMUNIZATIONS AND DATES (if applicable):

☐ HPV	☐ Influenza	☐ TDap	☐ Varicella	☐ OTHER:

GYNECOLOGICAL HISTORY

Do you have menstrual periods? ☐Yes ☐No If no: At what age did they stop?____________

If yes: First day of your last period? ____________ Are your periods regular? ☐Yes ☐No

Cycle Length:___________ Duration of Bleeding:_________

What was your age at your first period? ______________

Last Pap Smear:_____________ Any abnormal pap smears? ☐Yes ☐No ☐N/A

If yes, what year?____________ Treatment type?_____________ (e.g. LEEP/CRYO)

Have you ever had a mammogram? ☐Yes ☐No ☐N/A Date: __________________

Are you currently using contraception? ☐Yes ☐No What form?______________________

continued on reverse

HEALTH HISTORY QUESTIONNAIRE

FAMILY HISTORY

Check any of the diseases that run in your family **and** please note who had it: ☐**FAMILY HISTORY UNKNOWN**	MOTHER	FATHER	SISTER	BROTHER	GRANDMOTHER (Mother)	GRANDFATHER (Mother)	GRANDMOTHER (Father)	GRANDFATHER (Father)	CHILD	OTHER RELATIVE (i.e. Aunt)
Drug/Alcohol Abuse										
Cancer (If yes, type:)										
Diabetes										
Heart Attack										
High Blood Pressure										
High Cholesterol										
Osteoporosis										
Mental Illness										
Stroke										
Thyroid Disease										

HEALTH HABITS

Do you use tobacco products?.. ☐Yes ☐No ☐Quit

Number of cigarettes each day? ____________ For how many years? ___________

Other forms of tobacco used?______________

Do you drink alcohol? .... ☐Yes ☐No ☐Quit

How much/How often? __________________

Do you use other substances? .... ☐Yes ☐No ☐Quit If so, what? ______________________

PERSONAL HISTORY

Do you feel safe with current partner? .... ☐Yes ☐No ☐N/A

Has your partner ever been physically or emotionally abusive?.......................... ☐Yes ☐No ☐N/A

Have you ever been in a violent relationship?.. ☐Yes ☐No ☐N/A

Were you physically, mentally or sexually abused as a child? .... ☐Yes ☐No

Within the last 2 weeks, have you had little interest or pleasure in doing things? (Check box below)

☐ Not at all ☐ Several Days ☐ More than half the days ☐ Nearly every day ☐ Decline

Within the last 2 weeks, have you ever felt down, depressed or hopeless? (Check box below)

☐ Not at all ☐ Several Days ☐ More than half the days ☐ Nearly every day ☐ Decline

Within the last 2 weeks, have you been feeling nervous, anxious or on edge? (Check box below)

☐ Not at all ☐ Several Days ☐ More than half the days ☐ Nearly every day ☐ Decline

Within the last 2 weeks, have you been unable to stop or control worrying? (Check box below)

☐ Not at all ☐ Several Days ☐ More than half the days ☐ Nearly every day ☐ Decline

OBSTETRICAL HISTORY

Have you ever been pregnant?.. ☐Yes ☐No

How many times?__________ How many children? __________

Please list any complications: ____

How many miscarriages? Date(s) __________________ How many abortions? Date(s) __________________

Are you planning to become pregnant in the next year? .... ☐Yes ☐No ☐N/A

Do you have a history of infertility?.. ☐Yes ☐No

CLIENT SIGNATURE ________________________________ TODAY'S DATE ____________________

PRINT NAME ________________________________