

# Health History Questionnaire

The health history questionnaire you are about to fill out is important. It gives us information about your health, which will enable us to spend time discussing your medical condition. It will become part of your medical record and will remain confidential.

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

## Please check items that apply to your Medical History

- |  |   |
|--|---|
| <input type="checkbox"/> High blood pressure                 | <input type="checkbox"/> Hepatitis or Liver Disorders         |
| <input type="checkbox"/> Heart disease                       | <input type="checkbox"/> Kidney stones                        |
| <input type="checkbox"/> Cholesterol disorders               | <input type="checkbox"/> Kidney disease                       |
| <input type="checkbox"/> Blood clots                         | <input type="checkbox"/> Seizures                             |
| <input type="checkbox"/> Anemia or Blood Disorders           | <input type="checkbox"/> Migraine Headaches                   |
| <input type="checkbox"/> History of Blood transfusion        | <input type="checkbox"/> Neurological disorders               |
| <input type="checkbox"/> Diabetes                            | <input type="checkbox"/> Depression or Psychiatric Disorders  |
| <input type="checkbox"/> Thyroid Disease                     | <input type="checkbox"/> Cancer                               |
| <input type="checkbox"/> Asthma                              | <input type="checkbox"/> Birth Defects or Inherited Disorders |
| <input type="checkbox"/> Tuberculosis                        | <input type="checkbox"/> Anesthetic complications             |
| <input type="checkbox"/> Lung Disorders                      | <input type="checkbox"/> Infertility                          |
| <input type="checkbox"/> Stomach or Bowel Disorders          | <input type="checkbox"/> Abnormal Pap Smear                   |
| <input type="checkbox"/> Other medical disorders not listed: |   |

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### Current Medications:

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### List Medication Allergies:

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**Hospitalizations and Operations:**

No.	Month and Year	Illness or Operation	Complications
1.			
2.			
3.			
4.			
5.			

**Current Medical History**

**Menstrual History:**

Date of your last pap? \_\_\_\_\_

Yes or No Was it Abnormal?

The first day of your Last Period was? \_\_\_\_\_

***IF NO LONGER HAVING PERIODS SKIP TO BREAST HISTORY***

Yes or No Was it Abnormal?

Age at which you began having periods? \_\_\_\_\_

How often do you have periods? \_\_\_\_\_

How many days do you have flow? \_\_\_\_\_

Yes or No Do you have problems with irregular periods?

Yes or No Are you having problems with painful periods?

Yes or No Do you have problems with PMS?

**Breast History:**

Yes or No Have you had a Breast biopsy? If yes when? \_\_\_\_\_

Yes or No Are you currently having Breast pain?

Yes or No Are you currently having Nipple discharge?

Yes or No Do you currently feel a lump or mass in your breast?

**Sexual History:**

Yes or No Have you had more than one sexual partner in the last 6 months?

Yes or No Are you sexually active? , **if no then you may skip the next question**

Is your current partner: Male Female Both

What kind of birth control do you use?

Birth Control Pills      Condoms      Tubal      Vasectomy      IUD

Other: \_\_\_\_\_

Yes or No Have you recently been exposed to a sexually transmitted disease?

Yes or No Do you have any problems in your sex life?

Yes or No Do you have any questions about sex?

**Bladder History:**

- Yes or No Do you have bladder leakage when you cough, sneeze or exercise?
- Yes or No Do you have bladder leakage when walking to the bathroom?
- Yes or No Do you have frequent bladder infections?
- Yes or No Does your urine have a foul smell?
- Yes or No Do you have to get up frequently at night to Urinate?

**Social History**

What is your Current Marital Status? Single / Married / Divorced

- Yes or No Do you smoke?
- Yes or No Do you drink alcoholic beverages every day?
- Yes or No Do you use recreational drugs?
- Yes or No Are you now or have you been in a relationship with a person who Threatens or Physically hurts you?

**Infection Screening**

- Yes or No Have you had sexual contact with a person with AIDS or Hepatitis?
- Yes or No Are you a current or past IV drug user?
- Yes or No Do you have a current or past sexual partner who is bisexual, hemophiliac or an IV drug user?
- Yes or No Do you have a history or current exposure to gonorrhoea, syphilis, Chlamydia, or genital warts?
- Yes or No Do you have a history or current exposure of genital herpes?
- Yes or No **If indicated**, Have you had your HPV vaccine? **If yes next question.**
- Yes or No Has the series been completed?

**Screening Tests:**

Have you had any of the following tests?

Mammogram: If yes date \_\_\_\_\_ and Facility\_\_\_\_\_

Lipid Blood tests: If yes date of last? \_\_\_\_\_

Colonoscopy: if yes date of last? \_\_\_\_\_

Bone Density (Dexa Screening): If yes date \_\_\_\_\_ and Facility\_\_\_\_\_

**Family History**

Does anyone in your immediate family have any of these conditions?

- Yes or No    Breast cancer:                    If yes what relation? \_\_\_\_\_
- Yes or No    Ovarian cancer:                            If yes what relation? \_\_\_\_\_
- Yes or No    Colon cancer:                                If yes what relation? \_\_\_\_\_
- Yes or No    Diabetes:                                        If yes what relation? \_\_\_\_\_
- Yes or No    Bleeding disorder:                        If yes what relation? \_\_\_\_\_
- Yes or No    Heart attack:                                 If yes what relation? \_\_\_\_\_
- Yes or No    Osteoporosis:                                If yes what relation? \_\_\_\_\_
- Yes or No    Thyroid disease:                            If yes what relation? \_\_\_\_\_

**Past Pregnancies History**

How many times have you been Pregnant? \_\_\_\_\_    How many children are still living? \_\_\_\_\_  
 Number of Full term babies? \_\_\_\_\_                      Number of Premature babies? \_\_\_\_\_  
 Abortions? \_\_\_\_\_    Miscarriages? \_\_\_\_\_    Ectopic (Tubal Pregnancy)? \_\_\_\_\_

Child Born

Baby's Information

Complications

No.	Month / Year	Weight	Sex	Type of Delivery	Explain
1.					
2.					
3.					
4.					
5.					
6.					
7.					

Under *explain* please list specific complications like: Premature Labor, Still Born, Birth Defects, High Blood Pressure, Kidney Infection, Diabetes, Other: Free text

***If you are currently pregnant please continue to the next page:***

## Obstetric Questionnaire

Have any of these occurred in the Current Pregnancy? Please check the box for Yes

- Smoking
- Alcohol
- Street Drugs
- Fever
- Rash or Viral Illness
- Prescription Medications
- Abdominal Pain
- Vaginal Bleeding / Odor
- Over the counter Medications
- Vomiting
- Do you have cats?

## Genetics Screening

Have any of these occurred in your family or the baby's father's family? Check box for yes and specify what family member.

- Mediterranean (Italian, Greek) or Oriental background If yes what relation? \_\_\_\_\_
- Neural tube defect (spina bifida, anencephaly) If yes what relation? \_\_\_\_\_
- Ashkenazi Jewish (Tay-sachs) If yes what relation? \_\_\_\_\_
- Sickle Cell Disease / Trait If yes what relation? \_\_\_\_\_
- Huntington's Chorea If yes what relation? \_\_\_\_\_
- Birth Defects If yes what relation? \_\_\_\_\_
- Down Syndrome If yes what relation? \_\_\_\_\_
- Hemophilia If yes what relation? \_\_\_\_\_
- Muscular Dystrophy If yes what relation? \_\_\_\_\_
- Cystic Fibrosis If yes what relation? \_\_\_\_\_
- Mental Retardation If yes what relation? \_\_\_\_\_
- Other Hereditary Diseases If yes what relation? \_\_\_\_\_

The prenatal lab tests routinely obtained by Northeast OB/GYN Associates include a complete blood count, a blood type and screen, and screening tests for Rubella immunity, Syphilis, Hepatitis, and the Human Immuno-Deficiency Virus (the Cause of AIDS).