Health Questionnaire

Date_____ Patient Name_____ Age_____

Reason for Visit_____

Referred By_____ Allergies_____

Past Medical History/Problems

Asthma____ Bladder Infection____ Diabetes____ Heart Disease____ High Blood Pressure____

High Cholesterol____ Kidney Disease____ Lung Disease____ Migraines____ Phlebitis____

Seizures____ Thyroid Disease____ Other_____

Please describe additional problems_____

_____

Surgeries/Operations Hospital Date

_____

_____

_____

Family History (please check all that apply)

Breast Cancer____ Diabetes____ High Blood Pressure____ High Cholesterol____ Osteoporosis____

Ovarian Cancer____ Other Condition_____

Obstetrical History (Please indicate the number for each)

Pregnancies____ Miscarriages____ C-Sections____ Live Births____

Pre-Term Deliveries____ Ectopic Pregnancies____

Gynecological History

Date of Last Menstrual Period_____ Are you regular? _____

Contraception Use_____ Sterilization_____ Other_____

Date of Last Mammogram_____ Was it normal? _____

Date of Last PAP Smear_____ Was it normal? _____

Medication you are taking now (Include birth control pills)

_____ _____ _____

_____ _____ _____

_____ _____ _____

Do you drink alcohol? Never____ Rarely____ Occasionally____ Daily____

Do you smoke? Yes____ No____ How Long? _____ Packs per day? _____