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redefining women's healthcare
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HEALTH QUESTIONNAIRE

NAME: _____ DATE OF BIRTH: _____ AGE: _____

Race or Nationality of Parents: _____ Do you smoke?: _____ Yes _____ No

If no, did you ever smoke and If so, how much and when? _____

_____ Do you drink alcohol? _____ socially ___ daily

In a **life and death** situation would you refuse blood transfusion? _____ Yes _____ No

Marital Status, please circle: Married Single Divorced Widowed Separated

Allergies: _____

Current medications (including birth control pills): _____

MENSTRUAL HISTORY

	Answer Here
Age of first menstruation	
Duration of period (days)	
Average number of pads (or tampons) per day	
Date of last normal period	
Length of cycle (days from beginning of one period to the next)	

	Please Circle
Do you have hot flashes?	Yes No
Do you have any pre-menstrual symptoms?	Yes No
If yes, please mention	
Do you have severe cramps with menses?	Yes No

PREGNANCY

Do you think you are pregnant?	Yes No
Number of pregnancies (including present one if you are pregnant)	
Number of full term pregnancies	
Number of premature deliveries	
Number of miscarriages	
Number of elective abortions	
Number of living children	
Any children born weighing less than 5 pounds?	Yes No
Any complications with pregnancies or deliveries?	Yes No
If yes, please describe	

CONTRACEPTION

Are you presently using any contraception, including husband's vasectomy?	Yes No
If yes, what is it?	
Have you ever used birth control pills?	Yes No
If yes, when and for how long	
Have you ever had any serious problems with birth control pills?	Yes No
If yes, please explain	

PAST MEDICAL HISTORY

List any previous surgery you have had (type and year)
List any hospitalizations, age and reason (including childhood and childbirth)

HAVE YOU EVER BEEN TREATED FOR OR HAD ANY KNOWN INDICATION OF:	Please Circle
Disorder of eyes, ears, nose, or throat?	Yes No
Dizziness, fainting, convulsions, headache, speech defect, paralysis, stroke, or other mental or nervous disorder?	Yes No
Shortness of breath, persistent hoarseness or cough, blood spitting, bronchitis, pleurisy, asthma, emphysema, tuberculosis, or other chronic respiratory disorder?	Yes No
Chest pain, palpitations, high blood pressure, rheumatic fever, heart murmur, mitral valve prolapse, heart attack, or other disorder of the heart or blood vessels?	Yes No
Jaundice, intestinal bleeding, ulcer, hernia, appendicitis, colitis, hepatitis, diverticulitis, hemorrhoids, recurrent indigestion, or other disorder of stomach, intestines, liver, or gall-bladder?	Yes No
Sugar, albumin, blood or pus in urine, stone(s) or other disorder of kidney or bladder?	Yes No
Diabetes, thyroid, or other endocrine disorders?	Yes No
Neuritis, sciatica, rheumatism, arthritis, gout, or disorder of the muscles or bones, including the spine, back, or joints?	Yes No
Deformity, lameness, or amputation?	Yes No
Disorder of skin, lymph glands, cyst, tumor, cancer, leukemia, anemia, or other blood disorder?	Yes No

	Please Circle
Have you ever had an abnormal pap smear?	Yes No
If yes, what was done about it?	
Are you sexually active now?	Yes No
If no, were you in the past?	Yes No
What is your sexual preference?	
Were you 18 or younger at age of first intercourse?	Yes No
Have you had a total of 3 or more sexual partners?	Yes No
Any history of sexual abuse or rape?	Yes No
Any history of herpes or venereal warts? If yes, please circle which one(s)	Yes No
Have you ever had sexual contact with a male with a history of cancer of the penis (not testes)?	Yes No
Have you ever had sexual contact with a male previously married to a woman that had cervical cancer?	Yes No
Have you ever had gonorrhea, syphilis, Gardnerella, Trichomonas, chlamydia, mycoplasma, or Ureaplasma? If yes, please circle which one(s)	Yes No
Were you exposed to DES when your Mother was pregnant with you?	Yes No
Have you ever had any mental or physical disorder not mentioned above?	Yes No
If yes, please explain	

Have you had any serious injuries, broken bones, etc?	Yes No
If yes, please explain.	
Have you ever been treated, counseled, or joined a group because of drug or alcohol abuse?	Yes No
Have you had a change of weight (10 lbs. or more) in the past year?	Yes No
Have you been a patient in a hospital, clinic, sanitarium, or other medical facility not mentioned above?	Yes No
Have you had an EKG, X-ray, or other diagnostic test in the past 5 years?	Yes No
If yes, please describe.	
Have you ever had any discharge of the breast or reproductive organs?	Yes No

Please place the number of your corresponding **blood** relative in the list below that has had any of the following diseases:

_____ TB	_____ Stroke
_____ Diabetes	_____ Epilepsy
_____ Cancer	_____ Asthma
_____ Bleeding tendency	_____ Thyroid disease
_____ High blood pressure	_____ Mental illness or suicide
_____ Kidney disease	_____ Congenital defects
_____ Heart disease	_____ Genetic disease

(1) Mother
(2) Father
(3) Sister
(4) Brother
(5) Maternal Grandmother
(6) Maternal Grandfather
(7) Paternal Grandmother
(8) Paternal Grandfather
(9) Aunt
(10) Uncle

I UNDERSTAND THAT ALL CHARGES ARE DUE AT THE TIME OF THE VISIT. I UNDERSTAND THAT PRENATAL FEES ARE DUE BY THE SEVENTH MONTH (28 WEEKS, GESTATION).

Signature: _____ Date: _____