PATIENT HEALTH HISTORY QUESTIONNAIRE

Name: _____ Date_____

Reason for your visit: _____

PAST MEDICAL HISTORY:

(Do you have or have you ever had) ☐ None

- ☐ Alzheimer s Disease
- ☐ Anemia
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Breast Cancer
- ☐ Cardiac Arrhythmia
- ☐ Cervical Cancer
- ☐ Cholesterol, elevated
- ☐ Colon Cancer
- ☐ Congestive Heart Disease
- ☐ COPD (Lung Disease)
- ☐ Coronary Heart Disease
- ☐ Depression
- ☐ Diabetes Mellitus
- ☐ DVT (Venous Embolism)
- ☐ Epilepsy
- ☐ Esophageal Reflux
- ☐ Fibromyalgia
- ☐ Hepatitis (A, B, or C)
- ☐ Hernia
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Stone
- ☐ Lung Cancer
- ☐ Migraine Headache
- ☐ Mitral Valve Prolapse
- ☐ Myocardial Infarction
- ☐ Osteoporosis
- ☐ Ovarian Cancer
- ☐ Skin Cancer
- ☐ Stomach Cancer
- ☐ Stress Incontinence
- ☐ Stroke (CVA)
- ☐ Ulcer
- ☐ Uterine Cancer

COMMENTS:

PAST GYNECOLOGICAL HISTORY:

(Do you have or have you ever had) ☐ None

- ☐ Abnormal PAP Smear
- ☐ Amenorrhea (no menses)
- ☐ Anovulation
- ☐ Bartholin s Gland Cyst
- ☐ Cervical Cancer
- ☐ Chlamydia
- ☐ Condyloma Acuminatum
- ☐ Cystocele (Dropped Bladder)
- ☐ DES Exposure In Utero
- ☐ Dysplasia (Abnormal PAP)
- ☐ Dysfunctional Bleeding
- ☐ Dysmenorrhea
- ☐ Dyspareunia (painful sex)
- ☐ Ectopic
- ☐ Endometriosis
- ☐ Fibroid Uterus
- ☐ Gonorrhea
- ☐ Herpes Simplex (HSV)
- ☐ Hirsutism
- ☐ Human Papilloma Virus
- ☐ Incontinence
- ☐ Infertility
- ☐ Irregular Menses
- ☐ Menorrhagia
- ☐ Ovarian Cyst
- ☐ Pelvic Inflammatory Disease
- ☐ PMS
- ☐ Polycystic Ovaries (PCOS)
- ☐ Recurrent Vaginitis
- ☐ Syphilis
- ☐ Trichomonas
- ☐ Uterine Polyps
- ☐ Uterine Prolapse

COMMENTS:

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REPRODUCTIVE & MENSTRUAL HISTORY:

TOTAL # PREGNANCIES	# FULL TERM	# PREMATURE PREGNANCIES	# TERMINATION	# MISCARRIAGE	# OF ECTOPICS	# MULTIPLE BIRTHS	# LIVING

DATE OF LAST MENSTRUAL PERIOD: MENOPAUSE STATUS:

METHOD OF BIRTH CONTROL: ON HORMONE REPLACEMENT:

GENETIC HISTORY: ☐ None

- ☐ Chromosomal Disorder
- ☐ Genetic/Inherited Disorder
- ☐ Down s Syndrome
- ☐ Cystic Fibrosis
- ☐ Baby with Birth Defects
- ☐ Neural Tube Defects
- ☐ Sickle Cell Anemia
- ☐ Mental Retardation

COMMENTS:

PAST SURGICAL HISTORY: ☐ None

- ☐ Adenoidectomy
- ☐ Appendectomy
- ☐ Back Surgery
- ☐ Breast Augmentation
- ☐ Breast Lumpectomy
- ☐ Breast Mastectomy
- ☐ Bladder Lift
- ☐ C/Section
- ☐ CABG (coronary bypass)
- ☐ Cholecystectomy/Gallbladder
- ☐ Colon Resection
- ☐ Colonoscopy
- ☐ Cystoscopy
- ☐ D&C
- ☐ Ectopic Pregnancy
- ☐ Endometrial Ablation
- ☐ Gastric Bypass
- ☐ Hemorrhoid
- ☐ Hernia
- ☐ Hip Replacement
- ☐ Hysteroscopy
- ☐ Hysterectomy (abdominal)
- ☐ Hysterectomy (vaginal)
- ☐ Hysterectomy (laproscopic)
- ☐ Knee Surgery
- ☐ Laparoscopy
- ☐ Ovary Removal
- ☐ Pacemaker Implant
- ☐ Shoulder Surgery
- ☐ Splenectomy
- ☐ Thyroidectomy
- ☐ Tonsillectomy

COMMENTS:

GENERAL HEALTH SCREENING:

Date of last PAP Smear: _____ Date of last Mammogram: _____

Date of last Colonoscopy: _____ Date of last bone Density Scan: _____

Yes	No		
☐	☐	Do you smoke?	If so, how much? _____ And for how long? _____
☐	☐	Have you ever smoked?	If so, how much? _____ And for how long? _____
☐	☐	Do you drink regularly?	If so, how many drinks per week? _____
☐	☐	Do you use other recreational drugs?	If so, which ones? _____
☐	☐	Do you exercise regularly?	
☐	☐	Do you perform a monthly breast exam?	

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MEDICATIONS: ☐ None

	MEDICATION	DOSAGE	FREQUENCY	REASON
1.				
2.				
3.				

ALLERGIES: ☐ None

	MEDICATION/SUBSTANCE	REACTION
1.		
2.		

BREAST AND OVARIAN CANCER:

YES	NO		RELATIONSHIP	AGE AT DIAGNOSIS
☐	☐	Breast cancer before 50		
☐	☐	Ovarian Cancer		
☐	☐	Both breast & ovarian cancer (in an individual or family)		
☐	☐	Male breast cancer		
☐	☐	Ashkenazi Jewish ancestry & personal or family history of breast or ovarian cancer		
☐	☐	Osteoporosis		

COLON AND UTERINE CANCER:

YES	NO		RELATIONSHIP	AGE AT DIAGNOSIS
☐	☐	Uterine cancer before 50		
☐	☐	Colorectal cancer before 50		
☐	☐	Uterine and/or colorectal cancer AND ovarian, stomach, kidney/urinary tract, Brain or small bowel cancer (in an individual or family)		

FAMILY HISTORY: ☐ None

HEALTH PROBLEMS/CAUSE OF DEATH	AGE	FATHER	MOTHER	SIBLING	CHILDREN	UNCLE/ AUNT	GRAND PARENT

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