Comprehensive Health Questionnaire

We request you complete the following questionnaire so we can more effectively assess your needs. We realize this health history is quite lengthy, but its comprehensive nature will provide us with a fairly complete summary of your relevant medical history. If you have any difficulty in understanding or answering any of the questions, we will be happy to assist you with the problem areas at the time of your visit.

Please Complete all Items

Name: _____ Today's Date: _____

I would like to be addressed as: _____ Birth Date: _____

Primary Care Provider and others who provide me with care: _____

_____

I am here today because: _____

_____

_____

ALLERGY HISTORY - include reaction

Y / N Latex: Reaction _____

If you have a **medication** allergy, please specify below and include reaction to the medication:

Allergies:	**Reaction:**

IMMUNIZATION HISTORY

Y / N I have had chicken pox

Y / N I have had the chicken pox (varicella) vaccine _____
date

HPV Vaccination (Gardisil) _____ ¬ Series complete
date

PERSONAL MEDICAL HISTORY (please check if applicable)

¬ Endometriosis
¬ Painful periods
¬ Heavy periods
¬ PMS
¬ Fertility Problems
¬ Abnormal PAP smears and treatment
¬ Menopause Symptoms
¬ Urinary Leaking
¬ Osteopenia / Osteoporosis
¬ Cancer _____
¬ Bowel Problems - please specify below

¬ Migraine Headaches
¬ Heart Disease
¬ Diabetes
¬ High Blood Pressure
¬ High Cholesterol
¬ Stroke
¬ Heart Attack
¬ Kidney Disease
¬ Asthma
¬ Epilepsy
¬ Thyroid Problems - please specify below

Other Serious Medical Problems_____

_____

_____

_____

Name: _____

Last Pap Smear (date) _____ ¬ Normal ⊇ Abnormal ¬ N/A

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Last Mammogram (date) _____ ¬ Normal ⊇ Abnormal ¬ N/A
Last Cholesterol Test (date) _____ ¬ Normal ⊇ Abnormal ¬ N/A
Last Colonoscopy (date) _____ ¬ Normal ⊇ Abnormal ¬ N/A
Bone Density Scan (date) _____ ¬ Normal ⊇ Abnormal ¬ N/A
Current Contraception (include vasectomy or tubal ligation) _____

PAST SURGICAL HISTORY (please list dates and reasons for surgery)

_____
_____
_____
_____
_____
_____

Have you ever had a LEEP or cone biopsy of the cervix? Y / N
Procedure: _____ Date: _____

MEDICATION HISTORY

Medications/Vitamins/Supplements	Dose	Frequency

SOCIAL HISTORY

Relationship status: ( ) Single ( ) Married ( ) Divorced ( ) Separated ( ) Widowed ( ) Other
Occupation: _____
Exercise (frequency and type) _____
Smoking:
- ¬ Never smoked
- ¬ Previous smoker, quit date _____
- ¬ Current smoker - I smoke _____ pack(s) per day

Alcohol use: I have _____ drinks/beers per day / week. (circle)
Drug use:
- ¬ Never used "street drugs"
- ¬ Stopped using "street drugs"
- ¬ Currently use "street drugs"

Seat belt use: ¬ Always ¬ Sometimes ¬ Never
Are you currently or have you ever been in a relationship where you have been physically hurt, threatened, or made to feel afraid? ¬ Yes ¬ No
Sexual Orientation: ¬ Heterosexual ¬ Homosexual ¬ Bisexual ¬ Uncertain

Name: _____

OBSTETRIC HISTORY

Total Number of Pregnancies (including miscarriage and abortions) _____
Number of Living Children _____

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Number of Adopted/Step-children _____
Number of Miscarriages _____ Dates: _____
Number of Abortions _____ Dates: _____

Date of Delivery	Place	Weight	Sex	Type of Delivery (Vaginal / C-section)	Complications

Y HISTORY (list history for siblings, parents and grandparents)

- ¬ Family history unknown / Adopted

  Please list affected family member including maternal/paternal side:
- ¬ Breast Cancer _____
- ¬ Ovarian Cancer _____
- ¬ Colon Cancer _____
- ¬ Other Cancers (specify type) _____
- ¬ Osteoporosis _____
- ¬ Heart Attack _____
- ¬ Stroke _____
- ¬ Cardiovascular disease _____
- ¬ Clotting Disorders/DVT _____

Family Inherited Disorders_____
_____

Other Serious Medical Problems of Family Members_____
_____
_____

End of Questionnaire Thank you.