

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 _____

Y / N Yeast: Reaction _____

Y / N Eggs: Reaction _____

Medication Allergy: _____	Reaction: _____
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Other Allergies: _____	Reaction: _____
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Immunization History

Last Tetanus Immunization (date) _____

Rubella Immunization (date) _____

Chicken Pox or Vaccination (date) _____

HPV Vaccination (Gardasil) (date) _____

Family History - list history for parents, grandparents (maternal and paternal), brothers and/or sisters, children

(circle Y or N) **family member's relationship to you**

Y / N Breast Cancer _____

Y / N Ovarian Cancer _____

Y / N Colon Cancer _____

Y / N Other Cancers _____

Y / N Osteoporosis _____

Y / N Heart Attack _____

Y / N Stroke _____

Y / N Clotting Disorders/DVT _____

Inherited Disorders _____

Other Serious Medical Problems _____

() check here if your family history is unknown.

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Past Medical History	Normal	Abnormal	Never
Last PAP smear (date)			
Last Mammogram (date)			
Last Cholesterol (date)			
Last Colonoscopy (date)			
Bone Density Scan (date)			
Last HIV Screening (date)			

Current Contraception (include vasectomy or tubal ligation) _____

Last Menstrual Period (date) _____

Past Surgical History - please list dates and reasons for surgery.

Personal Medical Conditions

Endometriosis _____

Painful / Heavy Periods (circle) _____

PMS _____

Fertility Problems _____

Abnormal PAP smears and treatment _____

STDs _____

Menopause Symptoms _____

Urinary Leaking _____

Osteopenia / Osteoporosis (circle) _____

Cancer _____

Severe Headaches _____

Heart Disease _____

Diabetes _____

High Blood Pressure _____

High Cholesterol _____

Thyroid Problems _____

Asthma _____

Depression/Anxiety _____

Kidney Disease _____

Bowel Problems _____

Epilepsy _____

Other Serious Medical Problems _____

Medications/Vitamins/Supplements	Dose	Frequency

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Social History

() Single () Married () Divorced () Widowed () Other

Occupation _____

Exercise (frequency and type) _____

I smoke _____ pack(s) per day, and I quit _____ months / years ago. (circle)

I have _____ drinks/beers per day / week. (circle)

I wear my seatbelt. Sometimes Always Never (circle)

I never used "street drugs". (circle)

I use "street drugs". (circle)

I stopped using "street drugs". (circle)

Are you currently or have you ever been in a relationship where you have been / or are physically hurt, threatened, or made to feel afraid? (circle) Y / N

Sexual History

Are you currently sexually active? (circle) Y / N

Number of sexual partners in your lifetime _____

Sexual Orientation (circle) Heterosexual Homosexual Bisexual Uncertain

Obstetric History

Total Number of Pregnancies _____

Number of Living Children _____

Number of Adopted/Step-children _____

Number of Miscarriages _____

Number of Abortions _____

Date of Delivery	Place	Weight	Sex	Type of Delivery	Complications

End of Questionnaire

Thank you.

FOR OFFICE USE ONLY

Reviewed by _____

Date _____