HEALTH QUESTIONNAIRE

NAME: _____ **DATE:** _____

INTERNIST: _____ **REFERRING DR.:** _____

Please indicate the main reason for your visit: Check-up Pain Irregular bleeding Pregnancy Discharge Cancer Screening Family Planning Infertility Protruded Organ Sexual Problems Urinary Symptoms Other _____

Menstruation: Started at age:_____ **Number of days from start of one period to start of next** _____

Number of days period lasts:_____ **Date of last normal menstrual period (1st day)** _____

Obstetric history: Number of times you have been pregnant _____ **Full term babies** _____

Abortions _____ **Premature** _____ **Miscarriages** _____ **Stillborns** _____

Ages of children _____

PLEASE CIRCLE *YES* OR *NO* OR ANSWER THE QUESTIONS IF THEY PERTAIN TO YOU

Current method of birth control _____

Are your periods irregular	Yes	No	Do you bruise easily	Yes	No
Are your periods painful	Yes	No	Do you vomit after eating	Yes	No
Do you pass clots with your periods	Yes	No	Do you often eat between meals	Yes	No
Do you bleed between periods	Yes	No	Do your ankles swell	Yes	No
Do you bleed after douching or			Do you have varicose veins	Yes	No
intercourse	Yes	No	Do you get short of breath	Yes	No
Do you get tense before periods	Yes	No	Do you faint easily	Yes	No
Do you have any symptoms of			Do you get headaches	Yes	No
pregnancy	Yes	No	Do you get hot flashes	Yes	No
Is it difficult for you to become			Do you sleep poorly	Yes	No
pregnant	Yes	No	Do you wake up tired	Yes	No
Is sexual intercourse painful	Yes	No	Do you cry easily	Yes	No
Any problem with sexual intercourse	Yes	No	Have you been treated for		
Are you troubled with a discharge			nervousness	Yes	No
other than blood	Yes	No	Are you dissatisfied with your		
Does this discharge cause itching or			work	Yes	No
irritation	Yes	No	Are you dissatisfied with your family		
Do you have a history of female			situation	Yes	No
problems	Yes	No	Are you in a safe and nurturing		
Do you urinate frequently	Yes	No	relationship	Yes	No
Do you have the urge to urinate now	Yes	No	Has a past or present partner caused you		
Do you pass blood in your urine	Yes	No	Physical harm or forced you to do anything		
Do you lose urine when you cough or sneeze	Yes	No	You did not want to do	Yes	No

Have you been operated on in the last 5 years (list operations & dates) Yes No

_____

_____

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Does it feel like anything is pushing out of your vagina	Yes	No
Do you have to push anything up to empty your bowel or bladder	Yes	No
Are you constipated	Yes	No
Do you often have diarrhea	Yes	No
Do you ever pass blood in your stools	Yes	No
Do you ever have painful bowel movements	Yes	No
Do you ever have black stools	Yes	No
Have you gained or lost weight recently	Yes	No
Is your appetite or diet poor	Yes	No
Do you exercise regularly	Yes	No
Have you had any serious injuries	Yes	No
Have you had any blood transfusions	Yes	No
Do you drink more than 6 cups of coffee per day	Yes	No

Do you smoke cigarettes	Yes	No
How many times a week do you drink Beer_____ Wine_____ Liquor _____		
How many glasses per week do you drink Beer_____ Wine_____ Liquor_____		
Have you ever felt the need to cut down on your drinking	Yes	No
Have you ever had guilty feelings about your drinking	Yes	No
Have you ever felt annoyed by criticism of your drinking	Yes	No
Have you ever taken a morning "eye opener"	Yes	No
Do you use marijuana (pot) How often per week _____	Yes	No
Do you use cocaine (coke) How often per week _____	Yes	No

Are you taking any medications and, if so, please list _____

_____

Are you taking any "over the counter" drugs or any herbal or nutritional/health products – please list below

_____

DO YOU HAVE ANY ALLERGIES, IF SO, PLEASE LIST ***Yes*** ***No***

_____

Circle any of the following you have had in the past five years:

Arthritis	Cancer	High Blood Pressure	Lung Problems	Convulsions
Allergies	Diabetes	Kidney Problems	Tuberculosis	Osteoporosis
Anemia	Heart Condition	Sexually Transmitted Disease	Jaundice	

Other illness or medical problems: _____

Circle any of the following occurring in your family:

Arthritis	Convulsions	High Blood Pressure	Strokes	Multiple Births
Birth Defects	Diabetes	Mental Illness	Tuberculosis	Heart Disease
Cancer	Osteoporosis			

Are you parents living Yes No If deceased, cause of death _____