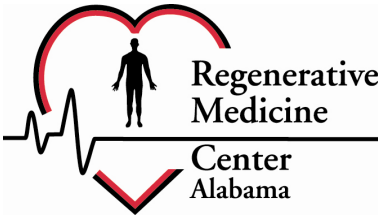
Larry D. Brock, M.D.
5901 Airport Blvd., Suite E
Mobile, AL 36609



Office: (251) 342-0505
Fax: (251) 342-0360

Health History Questionnaire for Women

(All questions contained in this questionnaire will be kept strictly confidential)

Name: *(Last, First, M.I.)*	**DOB** **Age**
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorce ☐ Widowed	
Occupation:	**Height:** **Weight:**

Personal Health History

Reason for Office Visit _____

_____

_____

_____

List current health problems for which you are being treated: _____

_____

_____

_____

What type of therapies have you tried for these problems or to improve your health over-all:

☐ diet modification ☐ fasting ☐ vitamins/minerals ☐ herbs ☐ homeopathy ☐ chiropractic

Allergies to Medication:

Name of Drug	Reaction

Current Medications:

Name of Medicine	Strength	Frequency Taken	Prescribing Physician

Personal Medical History

- □ Arthritis
- □ Allergies/hay fever
- □ Asthma
- □ Alcoholism
- □ Alzheimer's disease
- □ Autoimmune disease
- □ Blood pressure problems
- □ Bronchitis
- □ Cancer
- □ Chronic fatigue syndrome
- □ Carpal tunnel syndrome
- □ Cholesterol, elevated
- □ Circulatory problems
- □ Colitis
- □ Dental problems
- □ Depression
- □ Diabetes
- □ Diverticular disease
- □ Drug addiction
- □ Eating disorder
- □ Epilepsy
- □ Emphysema
- □ Eyes, ears, nose, throat problems
- □ Environmental sensitivities
- □ Fibromyalgia
- □ Food intolerance
- □ Gastroesophageal reflux disease
- □ Genetic disorder
- □ Glaucoma
- □ Gout
- □ Heart disease
- □ Infection, chronic
- □ Inflammatory bowel disease
- □ Irritable bowel syndrome
- □ Kidney or bladder disease
- □ Learning disabilities
- □ Liver or gallbladder disease (stones)
- □ Mental illness
- □ Mental retardation
- □ Migraine headaches
- □ Neurological problems
- □ (Parkinson's, paralysis)
- □ Obesity
- □ Osteoporosis
- □ Pneumonia
- □ Sexually transmitted disease
- □ Seasonal affective disorder
- □ Skin problems
- □ Sinus problems
- □ Stroke
- □ Thyroid trouble
- □ Tuberculosis
- □ Ulcer
- □ Urinary tract infection
- □ Varicose veins

Other _____

Women's Health History

Birth weight: _____ Were you breast fed? □Yes □ No

Were you a healthy infant? (birth to 2 years of age) □ Yes □ No

Age at onset of menstruation: _____ Period every _____days.

□ Heavy periods □ Irregularity □ Spotting □ Pain □ Discharge

Your weight on high school graduation: _____

Did you take birth control pills between your first period and first pregnancy? □ Yes □ No

Form(s) of birth control: _____

Number of pregnancies: _____ Number of live births: _____

Date of last menstruation: _____

Have you had a hysterectomy? □ Yes □ No Date: _____

List:	Hormone Replacements:	Type:	Date:
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Number of abortions/miscarriages: _____

Are you pregnant? □ Yes □ No Did you breast feed your children? □ Yes □ No

Have you had a □ D&C □ Cesarean section?

Any urinary tract, bladder, or kidney infections within the last year? □ Yes □ No

Any blood in your urine? □ Yes □ No

Any problems with control of urination? □ Yes □ No

Any hot flashes or sweating at night? □ Yes □ No

Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period? □ Yes □ No

Experienced any recent breast tenderness, lumps or nipple discharge? □ Yes □ No

□ Breast augmentation
□ Breast cancer
□ Fibrocystic breast disease
□ Endometriosis
□ Fibroids/ovarian cysts
□ Infertility
□ Premenstrual syndrome (PMS)
□ Decreased sex drive
□ Pelvic inflammatory disease
□ Vaginal infections
□ Sexually transmitted disease

Diagnostic Procedures:		**Normal**	
Pap Smear	Date: _____	□ Yes	□ No
Mammography	Date: _____	□ Yes	□ No
Colonoscopy	Date: _____	□ Yes	□ No
Bone Density	Date: _____	□ Yes	□ No
Cardiac Scan (coronary calcium score)	Date: _____	□ Yes	□ No

Other _____

Surgeries:

Year	Type	Hospital	Doctor

Other Hospitalizations:

Year	Problem	Hospital	Doctor

Have you ever had a blood transfusion? □ Yes □ No Date:

Childhood Illnesses: □ Measles □ Mumps □ Rubella □ Chicken Pox □ Rheumatic Fever □Polio

Health Habits and Personal Safety

Exercise:

□ Sedentary (No exercise) □ Mild Exercise (i.e., climb stairs, walk 3 blocks, golf)

□ Occasional Vigorous Exercise (i.e., work or recreation less than 4x/week for 30 min.)

□ Regular Vigorous Exercise (i.e., work or recreation 4x/week for 30 minutes)

Do you work out at a Gym? □ Yes □ No

Do you participate in other sports? □ Yes □ No

Body Composition

Do you consider yourself: □ underweight □ overweight □ just right

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? □ Yes □ No

Are you dieting? □ Yes □ No

If yes, are you on a physician prescribed medical diet? □ Yes □ No

# of meals you eat in an average day?_____

Salt Intake □ Hi □ Med □ Low

Fat Intake □ Hi □ Med □ Low

Caffeine: □ None □ Coffee □ Tea □ Cola # of Cups/Cans per day: _____

Alcohol:

Do you drink alcohol? □ Yes □ No

If yes, what kind? _____How many drinks per week? _____

Are you concerned about the amount you drink? □ Yes □ No

Have you considered stopping? □ Yes □ No

Have you ever experienced blackouts? □ Yes □ No

Are you prone to "binge" drinking? □Yes □ No

Tobacco:

Do you use tobacco? □ Yes □ No

Cigarettes-Pks/day ____ Chew-#/day ___ Pipe-#/day____

Cigars-#/day # of Years ____ or Year Quit ____

Drugs:

Do you currently use recreational or street drugs? □ Yes □ No

Have you ever given yourself street drugs with a needle? □ Yes No

What are you current health goals?

1._____ **3.**_____

2._____ **4.**_____

Family Health History

	Age	Age at Death	Significant Health Problems or Cause of Death		Age	Age at Death	Significant Health Problems or Cause of Death
Father				**Children**	☐ M ☐ F		
Mother					☐ M ☐ F		
Brothers and Sisters	☐ M ☐ F				☐ M ☐ F		
	☐ M ☐ F			**Grandparents (Mother's Side)**	Male		
	☐ M ☐ F				Female		
	☐ M ☐ F			**Grandparents (Father's Side)**	Male		
					Female		

Parents and Siblings

☐ Arthritis
☐ Asthma
☐ Alcoholism
☐ Alzheimer's disease
☐ Cancer
☐ Depression
☐ Diabetes
☐ Drug addiction
☐ Eating disorder
☐ Genetic disorder
☐ Glaucoma
☐ Heart disease
☐ Infertility
☐ Learning disabilities
☐ Mental illness
☐ Mental retardation
☐ Neurological disorders (Parkinson's, paralysis)
☐ Obesity
☐ Osteoporosis
☐ Stroke
☐ Suicide
Other _____

List Primary Care Physician:

Name:

Group:

Address:

Phone: **Fax:**

List Women's Specialist:

Name:

Group:

Address:

Phone: **Fax:**

Diagnosis:

1._____ **3.**_____

2._____ **4.**_____