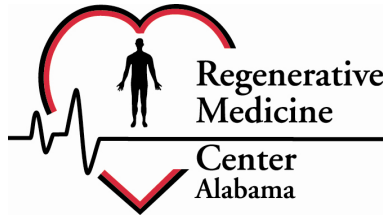


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## Health History Questionnaire for Women

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

<b>Name:</b> <i>(Last, First, M.I.)</i>	<b>DOB</b> <b>Age</b>
<b>Marital Status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorce <input type="checkbox"/> Widowed	
<b>Occupation:</b>	<b>Height:</b> <b>Weight:</b>

### 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

<b>Allergies to Medication:</b>
Name of Drug                      Reaction
_____
_____
_____

<b>Current Medications:</b>
Name of Medicine              Strength                      Frequency Taken              Prescribing Physician
_____
_____
_____
_____

## Personal Medical History

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

- |   |   |
|---|---|
| <input type="checkbox"/> Breast augmentation        | <input type="checkbox"/> Premenstrual syndrome (PMS)  |
| <input type="checkbox"/> Breast cancer              | <input type="checkbox"/> Decreased sex drive          |
| <input type="checkbox"/> Fibrocystic breast disease | <input type="checkbox"/> Pelvic inflammatory disease  |
| <input type="checkbox"/> Endometriosis              | <input type="checkbox"/> Vaginal infections           |
| <input type="checkbox"/> Fibroids/ovarian cysts     | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Infertility                |   |

<b>Diagnostic Procedures:</b>		<b>Normal</b>	
Pap Smear	Date: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mammography	Date: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Colonoscopy	Date: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bone Density	Date: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cardiac Scan (coronary calcium score)	Date: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other _____			
<b>Surgeries:</b>			
Year	Type	Hospital	Doctor
<b>Other Hospitalizations:</b>			
Year	Problem	Hospital	Doctor
Have you ever had a blood transfusion? <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____			
<b>Childhood Illnesses:</b>			
<input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio			



## 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
<b>Father</b>				<b>Children</b>	<input type="checkbox"/> M		
<b>Mother</b>					<input type="checkbox"/> F		
<b>Brothers and Sisters</b>	<input type="checkbox"/> M			<input type="checkbox"/> M			
	<input type="checkbox"/> F			<input type="checkbox"/> F			
	<input type="checkbox"/> M						
	<input type="checkbox"/> F			<b>Grandparents (Mother's Side)</b>	Male		
	<input type="checkbox"/> M				Female		
	<input type="checkbox"/> F			<b>Grandparents (Father's Side)</b>	Male		
	<input type="checkbox"/> M				Female		
	<input type="checkbox"/> F						

## Parents and Siblings

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Eating disorder       | <input type="checkbox"/> Neurological disorders (Parkinson's, paralysis) |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Genetic disorder      | <input type="checkbox"/> Obesity   |
| <input type="checkbox"/> Alcoholism          | <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> Osteoporosis                                    |
| <input type="checkbox"/> Alzheimer's disease | <input type="checkbox"/> Heart disease         | <input type="checkbox"/> Stroke  |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Infertility           | <input type="checkbox"/> Suicide   |
| <input type="checkbox"/> Depression          | <input type="checkbox"/> Learning disabilities | Other _____  |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Mental illness        |  |
| <input type="checkbox"/> Drug addiction      | <input type="checkbox"/> Mental retardation    |  |

### List Primary Care Physician:

Name:

Group:

Address:

Phone:

Fax:

### List Women's Specialist:

Name:

Group:

Address:

Phone:

Fax:

### Diagnosis:

1. \_\_\_\_\_ 3. \_\_\_\_\_

2. \_\_\_\_\_ 4. \_\_\_\_\_