WOMEN'S
HEALTH CENTER
Obstetrics & Gynecology

HEALTH QUESTIONNAIRE

Name_____Age_____Date of Birth_____

MEDICAL HISTORY:

Heart Disease	❑ Yes	❑ No
Rheumatic Fever	❑ Yes	❑ No
Heart Murmur	❑ Yes	❑ No
Lung Disease / Asthma	❑ Yes	❑ No
Stomach Problems	❑ Yes	❑ No
Bowel Disease	❑ Yes	❑ No
Liver Disease	❑ Yes	❑ No
Gall Bladder Disease	❑ Yes	❑ No
Hemorrhoids	❑ Yes	❑ No
Kidney / Bladder Problems	❑ Yes	❑ No
Gyn Problems	❑ Yes	❑ No
Sexually Transmitted Disease	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No
Thyroid Problems	❑ Yes	❑ No
Hypertension	❑ Yes	❑ No
Epilepsy	❑ Yes	❑ No
Headache	❑ Yes	❑ No
Cancer	❑ Yes	❑ No
Anemia	❑ Yes	❑ No
Back Problems	❑ Yes	❑ No
Ever had a blood transfusion?	❑ Yes	❑ No

Any Surgery?

Year	Type

Have you been hospitalized in the last 5 years for any reason other than childbirth or surgeries? ❑ Yes ❑ No

_____

_____

_____

FAMILY HISTORY:

Have your sisters, brothers, mother, father or grandparents ever had:

Hypertension	❑ Yes	❑ No
Heart Trouble / Stroke	❑ Yes	❑ No
Tuberculosis	❑ Yes	❑ No
Kidney Trouble	❑ Yes	❑ No
Epilepsy / Seizures	❑ Yes	❑ No
Arthritis	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No
Cancer	❑ Yes	❑ No
Sickle Cell Disease	❑ Yes	❑ No
Mental Illness	❑ Yes	❑ No

OB HISTORY:

No. of Total Pregnancies	_____
No. of Live Births	_____
No. of Still Births	_____
No. of Premature Births	_____
No. of Cesarean Sections	_____
No. of Abortions	_____
No. of Miscarriages	_____
No. of Ectopic Pregnancies	_____
Any Pregnancy Complications or Birth Defects?	❑ Yes ❑ No

GYN HISTORY:

Age of first period	_____
Are your periods regular?	❑ Yes ❑ No
How many days between each cycle?	_____days
How long does your period last?	_____days
Any clots or cramps during your period?	❑ Yes ❑ No
Date of last period	_____

Do you perform self breast exams?	❑ Yes ❑ No
Any history of breast problems (lumps / discharge)?	❑ Yes ❑ No
Using anything for birth control?	❑ Yes ❑ No
Any pelvic pain?	❑ Yes ❑ No
Having heavy / irregular periods?	❑ Yes ❑ No
Any pain with intercourse?	❑ Yes ❑ No
Any vaginal discharge or itching?	❑ Yes ❑ No
Ever had a partner who used drugs?	❑ Yes ❑ No
Ever had a partner who was bisexual?	❑ Yes ❑ No
Any history of sexual, emotional or physical abuse?	❑ Yes ❑ No
Any sexual problems you want to discuss?	❑ Yes ❑ No

Have you ever smoked?	❑ Yes ❑ No
How much?	_____ packs per day
How long?	_____ years
Last time smoked?	_____
Do you chew tobacco or dip snuff?	❑ Yes ❑ No
Do you drink alcohol?	❑ Yes ❑ No
Presently using street drugs?	❑ Yes ❑ No

Any problems (family/marital/social/sexual) which you would like to discuss with the doctor? ❑ Yes ❑ No