Vernon & Waldrep
OB-GYN ASSOC.

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Health Questionnaire

Date:_____

Name:_____

Reason for visit:_____

_____

Health Status

Present medications & dosage (prescriptions, vitamins, over-the-counter, supplements):

_____

_____

_____

Allergies (medications, latex, etc)_____

Last menstrual period (first day it began)_____

Last pap smear & result_____

Last mammogram & result_____

Last colonoscopy & result_____

Last bone density & result_____

Medical History

Have you in the (p)ast or do you (c)urrently have:

	P	C		P	C		P	C
Anemia			Migraine headaches			Endometriosis		
High blood pressure			Headaches			Gallbladder disease		
Diabetes			Hepatitis			Gastrointestinal ulcers		
Heart disease			Thyroid problems			Blood transfusion		
Heart murmur			Seizures			Hemorrhoids		
Heart palpitations			Kidney disease			Cancer (type):		
Chest pain			Asthma					
Rheumatic fever			Tuberculosis			Other:		
Depression			High cholesterol					

Hospitalizations/Surgeries

Date Diagnosis/Operation/Procedure Hospital

_____

_____

_____

_____

_____

Social History

Tobacco use: None_____Packs/day_____How long_____Want to quit?_____

Alcohol use: None_____ Drinks per day/week/month_____

Drug use: None_____ Drug_____ How often?_____

Occupation:_____ Do you wear seatbelts?_____

Are you sexually active?_____ Do you have intercourse?_____ How many sexual partners have you had?_____ How many sexual partners do you have?_____ Age at first intercourse?_____ Do you use condoms?_____ Consistently?_____

Are you (circle): married, divorced, single, widowed, in a committed relationship

Have you ever been in abusive relationship?_____ If yes (circle): physical/emotional/both

Family History – Please list any medical problems in your family

Mother_____

Father_____

Maternal grandmother_____

Maternal grandfather_____

Paternal grandmother_____

Paternal grandfather_____

Does ANYONE have (circle):
Breast cancer
Ovarian cancer
Colon cancer
Diabetes
Other cancer_____

OB/GYN History

Age when you had your first period_____ How many days between periods?_____

How many days does the flow last?_____ Is the flow (circle): light, medium, heavy, flood

Any PMS or menopause symptoms?_____

Have you in the (p)ast or do you (c)urrently have:

	P	C		P	C		P	C
Breast discharge			Urinary urgency			Human Papillomavirus (HPV)		
Breast lumps			Urine loss with cough			Chlamydia		
Breast pain			Bladder infections			Gonorrhea		
Painful intercourse			Abnormal pap smear			Syphilis		
Pelvic infection			HIV/AIDS			Genital warts		
Infertility			Vaginal infections			Herpes		

Have you been vaccinated against HPV (Human Papillomavirus) (Gardasil, Cervarix)?_____

Number of pregnancies_____ Miscarriages_____ Abortions_____ Number living_____

Date born Vaginal/C-section Sex Name Weight Problems/complications

_____

_____

_____

_____