Medical Health History Questionnaire

Patient Name:_____

(First) (Last)

Date of Birth:___/____/_____ Preferred Pharmacy:_____

Street: _____

Reason for Visit Today:_____

Other concerns:_____

Are you allergic to any medication? ▢ Yes ▢ No

If **yes**:

1. Medication:_____ Reaction:_____
2. Medication:_____ Reaction:_____

Are you taking any medication currently? (*Including any vitamins, supplements, birth control, IUD/ Implant, herbs*) ▢ Yes ▢ No

If **yes**:

Medication Dose Frequency

1. _____
2. _____
3. _____
4. _____
5. _____

Have you had any immunizations within the last year? ▢ Yes ▢ No

If **yes**, please list the immunization and the month.

_____

_____

_____

Gynecological History

When was your most recent pap smear? _____/_____/_____

Have you had sexual intercourse before? ▢ Yes ▢ No

Are you sexually active now? ▢ Yes ▢ No

Are you having any sexual problems? ▢ Vaginal dryness ▢ Pain with intercourse

▢ Low Libido ▢ Spotting after intercourse ▢ Other:_____

Within the last year, how many sexual partners have you had? _____

When having sex, do you always, sometimes, or never use protection? _____

Have you ever had an STI/STD before? ▢ Yes ▢ No

If **yes**:

1. Type of STI/STD:_____ Year:_____
2. Type of STI/STD:_____ Year:_____

Have you had the HPV vaccine? ▢ Yes ▢ No

What is your sexual orientation? ▢ Heterosexual ▢ Homosexual ▢ Bisexual ▢Prefer not to say

What is your form of birth control? (*Please check all that apply*)

▢ Condoms ▢ IUD ▢ Implant ▢Partner Vasectomy ▢ Tubal Ligation

▢ Birth Control Pills ▢ Hysterectomy ▢ Withdrawal ▢ Menopausal ▢ Pregnant

▢ Fertility Awareness Methods ▢ Abstinence ▢ None ▢ Other: (*please specify*)

_____

Date of first day of most recent period: ____/____/_____

Please circle one: Unknown Approximate Definite

Flow: Light Moderate Heavy

How many days does your period last? _____

Frequency of cycles (*days between*) _____

Do you have your period every month? ▢ Yes ▢ No

What age did you start your first period? _____

OR

What age did you start menopause? _____

Have you had any postmenopausal bleeding? ▢ Yes ▢ No

Have you had any hormone replacement therapy? ▢ Yes ▢ No

Do you take any Flomax or Avodart? ▢ Yes ▢ No

Do you have any trouble passing urine? ▢ Yes ▢ No

When was your most recent:

Mammogram: ____/____/_____ ▢ N/A

Colonoscopy: ____/____/_____ ▢ N/A

Bone Density: ____/____/_____ ▢ N/A

Pelvic Ultrasound: ____/____/_____ ▢ N/A

Pregnancies

How many pregnancies have you had?

Live Births:_____ Miscarriages:_____ Abortions:_____ Ectopic:_____

How old were you when you had your first child? _____

Child Information

Birthday	Term Length	M/F	Weight	Gest. Wk |	Epidural? |	Vaginal/C-section	
/ /	Full Prem		___lbs ___oz				
/ /	Full Prem		___lbs ___oz				
/ /	Full Prem		___lbs ___oz				
/ /	Full Prem		___lbs ___oz				
/ /	Full Prem		___lbs ___oz				
/ /	Full Prem		___lbs ___oz				

Family History

Do any of your family members, (mother, father, siblings and grandparents), have any medical problems or disabilities? (example: cancer, diabetes, high blood pressure, heart disease…)

▢ Yes ▢ No

If **yes**, please specify:_____

_____

Social History

Do you have any current or past history of smoking tobacco?

▢ Yes, current ▢ Yes, in the past ▢ No, never

If **yes,** how many years have you smoked for? _____

How many packs do you smoke in a week? _____

What is your occupation?_____ Employed? ▢ Yes ▢ No

What is your highest level of education?

▢ Some high school ▢ 12th grade ▢ Some college ▢ 2 year college

▢ 4 year college ▢ Graduate school

What is your relationship status?

▢ Single ▢ Married ▢ Divorced ▢ Separated ▢ Widowed ▢ Other:_____

Do you live alone or with others? _____

How often do you exercise? (*circle one*)

None (0) Occasionally (1-2) Moderately (3-5) Heavily (5+)

Are you on any special diets? (*circle one)*

Vegetarian Vegan Diabetic Carbohydrate Specific:_____

What is your general stress level?

1 2 3 4 5 6 7 8 9 10

Low High

How many times a week do you drink alcohol? _____

How many times a week do you drink caffeine? (*coffee, soda and tea*) _____

Do you use any illicit drugs? ▢ Yes ▢ No

If **yes**, please specify:_____

Do you wear your seatbelt routinely? ▢ Yes ▢ No ▢ Sometimes

Do you wear sunscreen routinely? ▢ Yes ▢ No ▢ Sometimes

Do you have an advanced directive? ▢ Tes ▢ No

In case of any emergency, is a blood transfusion acceptable? ▢ Yes ▢ No

Surgeries

Please list and date all surgeries and procedures below. (*This includes colonoscopies, endoscopies, and c-sections*)

1. _____Year:_____
2. _____Year:_____
3. _____Year:_____

Past Medical History

Please select yes or no for the following that apply to **YOU**. These can be historical or present.

Abuse/Domestic Violence	▢ Yes	▢ No	**Acid Reflux**	▢ Yes	▢ No
Allergies *(food, seasonal)*	▢ Yes	▢ No	**Acne**	▢ Yes	▢ No
Anxiety Disorders	▢ Yes	▢ No	**Anemia**	▢ Yes	▢ No
Anxiety Disorders	▢ Yes	▢ No	**Arrhythmia**	▢ Yes	▢ No
ART *(IVF or FET)*	▢ Yes	▢ No	**Arthritis**	▢ Yes	▢ No
Autoimmune Disease	▢ Yes	▢ No	**Birth Defects**	▢ Yes	▢ No
Blood Transfusion	▢ Yes	▢ No	**Breast Cancer**	▢ Yes	▢ No
Breast Problem	▢ Yes	▢ No	**Cancer**	▢ Yes	▢ No
Deep Vein Thrombosis	▢ Yes	▢ No	**Depression**	▢ Yes	▢ No
Dermatologic Disorders	▢ Yes	▢ No	**Diabetes**	▢ Yes	▢ No
Drug or Latex Allergies	▢ Yes	▢ No	**Eczema**	▢ Yes	▢ No
Eating Disorder	▢ Yes	▢ No	**Endometriosis**	▢ Yes	▢ No
Fibromyalgia	▢ Yes	▢ No	**Gest. Diabetes**	▢ Yes	▢ No
Gastrointestinal Problems	▢ Yes	▢ No	**Headaches**	▢ Yes	▢ No
Heart Disease/Attack	▢ Yes	▢ No	**Heart Bypass**	▢ Yes	▢ No
Heart Problems	▢ Yes	▢ No	**Hepatitis/HIV**	▢ Yes	▢ No
Hematologic Disorders	▢ Yes	▢ No	**High Cholesterol**	▢ Yes	▢ No
History of Abnormal Pap	▢ Yes	▢ No	**History of STI/STD**	▢ Yes	▢ No
Hypertension	▢ Yes	▢ No	**Infertility**	▢ Yes	▢ No
Kidney/Bladder Problems	▢ Yes	▢ No	**Kidney Disease**	▢ Yes	▢ No
Liver Disease	▢ Yes	▢ No	**Lupus**	▢ Yes	▢ No
Neurological/ Epilepsy	▢ Yes	▢ No	**Osteoporosis**	▢ Yes	▢ No
Ovarian Cancer	▢ Yes	▢ No	**P.C.O.S.**	▢ Yes	▢ No
Pre-Eclampsia	▢ Yes	▢ No	**Polyps**	▢ Yes	▢ No
Psychiatric Illness	▢ Yes	▢ No	**Pulmonary (Asthma)**	▢ Yes	▢ No
Thrombophilias/Clots	▢ Yes	▢ No	**Stroke**	▢ Yes	▢ No
Thyroid Problems	▢ Yes	▢ No	**Trauma/Violence**	▢ Yes	▢ No
Uterine Cancer	▢ Yes	▢ No	**Varicose Veins**	▢ Yes	▢ No

Other:_____