THE WOMAN'S GROUP

Date:_____

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record

Name *(Last, First, M.I.):*	**DOB:** / /
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring doctor:	**Date of last exam:** / / **Reason for Visit:**

REPRODUCTIVE HISTORY

MENSTRUAL

Age Menarche:	**Cycle Interval:** (days) **Menses Duration:** (days) **Flow:** Heavy Moderate Light	
LMP: _____	**Breakthrough Bleeding:** Yes/No **Number of Pads/Tampons:** ___/per day	
Certainty of LMP Date: Sure/Unsure	**Method of Birth Control:** ☐ Condoms ☐ IUD ☐ OCP's ☐ Depo Provera ☐ Diaphragm ☐ Other	Yes
Office Pregnancy Test: Yes/No **Home Pregnancy Test:** Yes/No	**Menopause Status:** Premenopausal/Peri menopausal/Post menopausal **Age Menopause:** **On HRT?** Yes/No **Medication name:**	

Date of Last Pap smear: / / **Any Abnormal?** Yes/No **Date of Last Mammogram:** / / **Any Abnormal?** Yes/No

PREGNANCY SUMMARY

Total Pregnancies #	Full Term #	Premature #	Elective Abortions #	Miscarriages #	Ectopic Pregnancies #	Multiple Births #	Total Living #

PREGNANCY DETAILS (Last 8)

Date	Weeks	Hrs in Labor	Weight	Sex	Type	Anesthesia (epidural/IV/General Local/None)	Preterm Labor	Complications (Vacuum, forceps, VBAC, etc.)	Hospital/ MD
				M/F	Vag/CS		Yes/No		
				M/F	Vag/CS		Yes/No		
				M/F	Vag/CS		Yes/No		
				M/F	Vag/CS		Yes/No		
				M/F	Vag/CS		Yes/No		
				M/F	Vag/CS		Yes/No		
				M/F	Vag/CS		Yes/No		

ALLERGY LIST

ALLERGY NAME	REACTION
Drug Allergies:	
Food Allergies:	
Environmental Allergies:	
Other Allergies:	

MEDICATION LIST

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Drug Name	Dose and Frequency	Reason for Taking/Prescriber's Name

THE WOMAN'S GROUP

Date:_____

PAST MEDICAL HISTORY (Obstetrical, Gynecologic, Breast, Cardiovascular, Neurologic, Hematology, Digestive, Endocrine, Dermatology, Urology, Psychiatry)		
Diagnosis/Year	Details	Treatment/Follow-up

PAST SURGICAL HISTORY (Obstetrical, Gynecologic, Breast, Cardiovascular, Neurologic, Hematology, Digestive, Endocrine, Dermatology, Urology, Psychiatry)		
Diagnosis/Year	Details	Procedure/Treatment/Follow-up

FAMILY HEALTH HISTORY		
Relationship	**Age**	**Significant Health History (**Heart Problems, Diabetes, Cancer, etc.)
Mother		
Father		
Grandmother		
Grandfather		

SOCIAL HISTORY		
History of Substance Abuse? *Explain:*	☐ Yes	☐ No
Cigarettes: How many years? Pack/Day: Year Quit:	☐ Yes	☐ No
Exercise: **Active** **Moderate** **Minimal** **Sedentary**	☐ Yes	☐ No
History of Domestic Violence? *Explain:*	☐ Yes	☐ No
Occupation:		