Health Questionnaire

Date:_______________

THE PURPOSE OF THIS FORM IS TO HELP YOU TO REMEMBER EVERYTHING THAT SHOULD BE CHECKED. PLEASE FILL OUT COMPLETELY:

Name: ____ Age: _______ DOB: ______/_______/________
(First) (Middle) (Last)

CIRCLE **THE MAIN REASON YOU CAME TO SEE THE DOCTOR:**

Routine Check-up **Cancer Test** **Birth Control** **Infertility** **Pain** **Irregular Bleeding**

Possible Pregnancy **Discharge** **Urinary symptoms** **Other: ____________________**

PERIODS: Age when started_______ Number of days from start of one to start of next period __________
Number of days period lasts ________ Date of last period (1st day) _____/_____/_______
How many times have you been pregnant?______ How many full term babies?_________Prematures?_____
Miscarraiges?________ Stillborns?_________Ages of children?___________________________________
Do you use birth control? Yes / No If yes, what kind? ____

PLEASE *CIRCLE* Y (YES) OR N (NO) AFTER THE FOLLOWING QUESTIONS:

Question		
Are your periods regular?	Y	N
Are they painful?	Y	N
Do you pass clots with them?	Y	N
Do you bleed between periods?	Y	N
Are relations uncomfortable?	Y	N
Are you troubled with a discharge?	Y	N
Does it itch, burn or irritate?	Y	N
Do you have any breast discharge?	Y	N
Do you have hot flashes?	Y	N
Ever had a kidney or bladder infection?	Y	N
Do you have pain when you urinate?	Y	N
Do you urinate too often?	Y	N
Do you lose urine when you cough or laugh?	Y	N
Do you have pressure in your pelvis?	Y	N
Have you ever vomited blood?	Y	N
Ever passed black tarry stools?	Y	N
Any recent change in your bowel habits?	Y	N
Ever had any thyroid problems?	Y	N
Are you unduly sensitive to heat or cold?	Y	N
Any unusual hair loss or growth?	Y	N
Any unusual or prolonged bleeding from cuts?	Y	N
Any changing skin blemishes?	Y	N
Ever see double or blurred?	Y	N
Do you frequently lose your balance?	Y	N
Do you get short of breath easily?	Y	N
Do you get headaches often?	Y	N
Ever had any serious injuries?	Y	N
Do you take any medication?	Y	N
Take birth control pills?	Y	N
Other medication?______________________________		
Any blood transfusions or reactions?	Y	N
Ever had any operations?	Y	N

List operations and dates: ______________________________
____
____

List Any Allergies: ______________________________
____
____

CIRLCE **ANY OF THESE YOU HAVE HAD:**

Anemia(low blood) Arthritis Asthma Convulsions Diabetes Heart trouble High Blood Pressure

Jaundice Kidney trouble Lung trouble Migraine headaches Phlebits Stroke TB VD

CIRCLE **ANY OF THE FOLLOWING OCCURING IN YOUR FAMILY:**

Arthritis Birth defects Cancer Diabetes High Blood Pressure Mental illness Strokes TB Twins

WHEN WAS YOUR LAST PAP SMEAR? ____

WHEN WAS YOUR LAST PHYSICAL EXAM? ____