



WOMEN'S
HEALTH
ALLIANCE

Women's Health Alliance

PATIENT QUESTIONNAIRE

Name _____ SSN _____
 Address _____
 Phone _____ Birthdate _____ Race _____
 Religion _____ Employer _____
 Occupation _____ Marital Status M S D W
 Name of spouse _____
 Chief Complaint (Why you are in the physician's office today?): _____

PAST, FAMILY, AND SOCIAL HISTORY:

I. PAST HISTORY:

Prior major illnesses and injuries: _____

 Prior operations: _____

 Current medications (prescriptions and over the counter): _____

 Allergies: _____
 Do you have any reactions to medicine? Yes No If yes, please list _____

Are your immunizations current?	Date	Date
MMR – Measles, Mumps, Rubella ... <input type="checkbox"/> Yes <input type="checkbox"/> No		Pneumoccal ... <input type="checkbox"/> Yes <input type="checkbox"/> No
Chicken pox <input type="checkbox"/> Yes <input type="checkbox"/> No		Flu vaccine <input type="checkbox"/> Yes <input type="checkbox"/> No
Polio <input type="checkbox"/> Yes <input type="checkbox"/> No		Hepatitis B <input type="checkbox"/> Yes <input type="checkbox"/> No
TD – Tetanus-Diphtheria <input type="checkbox"/> Yes <input type="checkbox"/> No		

Have you had any transfusions? Yes No If yes, list date(s): _____
 Have you had these infections in the past? Rheumatic fever Yes No Hepatitis B . . . Yes No
 Hepatitis A Yes No Chicken pox .. Yes No
 German Measles Yes No

II. FAMILY HISTORY: Has any relative had any of the following illnesses?

Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship _____	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship _____
Location _____			Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Kidney trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Heart trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Suicide	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Heart attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Mental illness	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

III. SOCIAL HISTORY: Level of education _____

Do you use drugs? Yes No Name of drug _____
 Do you use tobacco? Yes No Number smoked per day _____
 Do you use alcohol? Yes No Amount per day _____
 Have you ever been abused? Yes No Physically? Yes No Sexually? Yes No

PERSONAL HEALTH HISTORY

Usual weight: _____

Recent weight change Yes No

Do you or have you ever had the following problems?

- Any skin rashes Yes No
 - lumps Yes No
 - itching Yes No
 - dryness Yes No
 - color change in
 - hair or nails Yes No
 - chicken pox Yes No
- Any head injuries Yes No
 - frequent or severe
 - headaches Yes No
- Any eye disease Yes No
 - injury Yes No
 - impaired sight Yes No
- Any ear disease Yes No
 - injury Yes No
 - impaired hearing Yes No
- Any problem with nose Yes No
 - mouth Yes No
 - sinuses Yes No
 - throat Yes No
 - neck Yes No
- Any breast problems
 - such as lumps Yes No
 - nipple discharge Yes No
 - pain Yes No
 - tenderness Yes No
- Any chest problems such as
 - chronic coughing Yes No
 - asthma Yes No
 - wheezing Yes No
 - emphysema Yes No
 - pneumonia Yes No
 - spitting up blood Yes No
 - pain Yes No
 - shortness of breath Yes No

- Any heart trouble Yes No
 - high blood pressure Yes No
 - rheumatic fever Yes No
 - heart murmurs Yes No
 - chest pain Yes No
 - palpitations Yes No
 - swelling Yes No
 - past EKG or other
 - heart tests Yes No
- Any trouble swallowing Yes No
 - indigestion Yes No
 - constipation Yes No
 - diarrhea Yes No
 - change in bowel habits Yes No
 - rectal bleeding Yes No
 - black stools Yes No
 - hemorrhoids Yes No
 - liver or gall bladder
 - trouble Yes No
 - hepatitis Yes No
- Frequent urination Yes No
 - painful urination Yes No
 - leaking of urine when
 - coughing or sneezing Yes No
 - bladder/kidney
 - infections Yes No
 - stones Yes No
- Any joint pain Yes No
 - arthritis Yes No
 - backache Yes No
 - muscle pains or cramps Yes No
 - varicose veins Yes No
 - blood clots Yes No
 - inflammation in veins Yes No

- Any thyroid trouble Yes No
 - heat or cold intolerance Yes No
 - excessive sweating Yes No
 - excessive thirst Yes No
 - excessive hunger Yes No
 - excessive urination Yes No
 - diabetes Yes No
- Any nervousness Yes No
 - tension Yes No
 - moodiness Yes No
 - depression Yes No
 - anxiety Yes No
- Any trouble with fainting Yes No
 - blackouts Yes No
 - seizures Yes No
 - local weakness Yes No
 - numbness Yes No
 - tingling Yes No
 - tremors Yes No
 - memory loss Yes No
- Any problems with
 - anemia Yes No
 - easy bruising Yes No
 - bleeding Yes No
- Have you ever had a
 - blood transfusion Yes No
- Any problems with swelling
 - of lymph nodes Yes No

Would you like additional information about your health Yes No

Topic _____

GYNECOLOGIC HISTORY

- Age at onset of menses _____ Are they regular? Yes No
- Cycle _____ days (from start to start) How long do they last? _____
- Flow: light moderate heavy Do you have pain or cramps? Yes No
- Do you require medications for menstrual cramps? Yes No
- Date of last period _____
- Are you taking birth control pills now? Yes No
- Have you taken birth control pills in the past? Yes No
 - Date when you stopped taking birth control pills _____
- Do you have any side effects from birth control pills? Yes No
- Have you used any of the following birth control methods:
 - condoms Yes No
 - foam Yes No
 - diaphragm Yes No
 - IUD Yes No
 - tubal ligation Yes No
 - vasectomy Yes No
 - Depo-provera Yes No
 - other _____
- Date of last pap smear _____ Was it normal Yes No
- History of abnormal pap smears: _____
- History and/or treatment of infertility: _____

- Have you had any of the following sexually transmitted diseases?
 - herpes Yes No
 - chlamydia Yes No
 - gonorrhea Yes No
 - syphilis Yes No
 - AIDS Yes No
 - genital warts Yes No
- Have you had
 - vaginal infection Yes No
 - discharge Yes No
 - itching Yes No
- Have you had any symptoms of menopause such as
 - night sweats Yes No
 - hot flushes Yes No
 - heart palpitations Yes No
 - irregular menses Yes No
 - unusual bleeding Yes No
 - vaginal dryness Yes No
 - irritability Yes No
- If postmenopausal, do you ever experience any vaginal bleeding Yes No
- Number of pregnancies _____
 - miscarriages _____
 - deliveries _____
 - living children _____

Thank you for completing this questionnaire which will be helpful in understanding your health history.

Patient's signature _____ Date _____

Received by (provider) _____ Date _____