For Female Patients Age 13 and Up

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:**	
Previous or referring doctor:		**Date of last physical exam:**	

TYPES OF PERFORMANCE

PHYSICAL HEALTH

Do you exercise?

___ No
___ Mild exercise (i.e. climb stairs, walk 3 blocks, bike riding)
___ Occasional vigorous exercise (i.e. sports or recreation, less than 4x/week for 30 minutes)
___ Regular vigorous exercise (i.e. sports or recreation 4x/week for 30 minutes)

What kinds of exercise do you enjoy?

What do you like most about exercise?

What do you like least about exercise?

Physical accomplishments that you are proud of:

ACADEMIC / DEVELOPMENTAL HEATH

Where do you go to school?

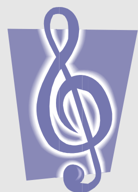
What do you like most about school?

Do you have a favorite class?

What do like least about school?

Are you struggling with any particular class?

Academic achievements that you are proud of:



CREATIVE EXPRESSION / EMOTIONAL HEALTH

Do you have a creative outlet (music, art, drama, writing, etc.)? This includes things like listening to music, reading a book for pleasure or visiting with friends. Things like Yoga or Dance Class would be both physical and creative expression (it's okay to have items in more than one category).

How often do you participate in a creative activity?

Do you feel like you have good stress management skills?

What creative accomplishments are you proud of:

PERSONAL HEALTH HISTORY

Immunizations and dates:	☐ DTAP		☐ Pneumonia	
	☐ Hep A		☐ Chickenpox	
	☐ Hep B		☐ Meningitis	
	☐ Influenza		☐ MMR *Measles, Mumps, Rubella*	
	☐ Guardisil (HPV)		☐ Other:	

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion? ☐ Yes ☐ No

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

Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Diet	Are you dieting?	☐	Yes	☐	No
	If yes, are you on a physician prescribed medical diet?	☐	Yes	☐	No
	# of meals you eat in an average day?				
Alcohol	Do you drink alcohol?	☐	Yes	☐	No
	If yes, what kind?				
	How many drinks per week?				
	Are you concerned about the amount you drink?	☐	Yes	☐	No
	Have you considered stopping?	☐	Yes	☐	No
	Have you ever experienced blackouts?	☐	Yes	☐	No
	Are you prone to "binge" drinking?	☐	Yes	☐	No
	Do you drive after drinking?	☐	Yes	☐	No
Tobacco	Do you use tobacco?	☐	Yes	☐	No
	☐ Cigarettes – pks./day ☐ Chew - #/day ☐ Pipe - #/day ☐ Cigars - #/day				
	☐ # of years ☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?	☐	Yes	☐	No
	Have you ever given yourself street drugs with a needle?	☐	Yes	☐	No
Sex	Have you ever had sex? With men, women or both? (circle one)	☐	Yes	☐	No
	If yes, any discomfort with intercourse?	☐	Yes	☐	No
	If yes, what type of birth control is being used?				
	Have you ever had an STD?	☐	Yes	☐	No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	☐	Yes	☐	No
	Have you ever been pregnant?	☐	Yes	☐	No
Family Life	Physical and/or mental abuses have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your doctor?	☐	Yes	☐	No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Grandmother** Maternal		
Mother					
Sibling	☐ M ☐ F		**Grandfather** Maternal		
	☐ M ☐ F		**Grandmother** Paternal		
	☐ M ☐ F		**Grandfather** Paternal		
	☐ M ☐ F		**Other:**		
	☐ M ☐ F				
	☐ M ☐ F				

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

OTHER PROBLEMS

Age at first period:	Date of last period:	Period every ___ Days

Heavy periods, irregularity, spotting, pain or discharge?	☐	Yes	☐	No
Any urinary tract, bladder or kidney infections?	☐	Yes	☐	No
Do you have menstrual tension, pain, bloating, irritability or other symptoms at or around time of period?	☐	Yes	☐	No
Experienced any recent breast tenderness, lumps or nipple discharge?	☐	Yes	☐	No
Have you ever had a pap exam?	☐	Yes	☐	No

Check if you have, or have had any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

Please use the space below to list any questions or concerns you would like to speak with the doctor about in private: