HARBOUR WOMEN'S HEALTH

OBSTETRICS ● GYNECOLOGY ● UROGYNECOLOGY

Health History Questionnaire - 40 Years Old & Up Date:_____

Name:_____ Date of Birth:_____

Medical History:

1. What was the first day of your last menstrual period? _____
   How many menstrual periods a month do you have?_____
   How far apart are they?_____
   Age your period (menses) started _____ Stopped (menopause)_____
   Menopause Concerns? Yes / No
   Pain or bleeding with Intercourse? Yes / No
   Would you describe your period as light/medium/heavy)?_____
   Is your period painful? Yes / No
   How many days does your period last?_____

2. When was your last pap smear?_____ Was it normal?_____ Where?_____
   Have you ever had an abnormal pap smear? Yes / No
   If so, when?_____
   If so, did you have to have (please circle) Colposcopy / Leep / Cold Knife Conization
   Have you had the Gardasil/HPV vaccine? _____ If no and you are under 45 years old would you like to discuss this today? _____

3. Are you currently having any of the following symptoms (please circle)

Nausea/Vomiting	Breast Tenderness	Fatigue
Constipation	Pain with Urination	Dizziness/Lightheadedness
Spotting/Cramping	Problems controlling urine (with cough, sneeze or exercise)	

4. Please list any MEDICATION/ DRUG ALLERGIES and the type of reaction you had:

Medicine/Food/Latex/Environmental	Type of Reaction

5. Please list medications (prescriptions and non-prescriptions), vitamins or supplements you are taking:

Name of Medication	Dose & Times per day	For what reason?	How Long?	Prescribed by?

6. Please list any past or present medical problems:

_____

_____

_____

7. Please list any previous illness or hospitalization **(EXCLUDING CHILDBIRTH)**

_____

_____

_____

8. Please list all surgeries and hospitalizations you have had and the approximate year in which they occurred, including tonsils, hernias, tubal ligations, etc**. EXCLUDING CHILDBIRTH**

_____

_____

_____

9. Have you ever had a blood transfusion? Yes/No Why?_____

10. If applicable, please provide the following information about previous pregnancies:

	Type of delivery: vaginal delivery, vaginal delivery assisted by forceps or vacuum, cesarean section (if miscarriage or abortion, please indicate here and leave rest of rows blank) If cesarean section, why?	Date of delivery	Gestational age at delivery	Infant's gender and weight (if twins, please put both in same row)	Place of delivery	Please list any pregnancy complications (Hypertension, Diabetes, Other)
1						
2						
3						
4						
5						

Health Screening and Preventative Activities:

11. When was the last time you had: Physical Exam:_____ Colonoscopy:_____

Cholesterol Screening :_____ Mammogram:_____ Bone Density Screening:_____

Behaviors and Habits Affecting Health:

12. Please describe your use of tobacco products:

Circle: Never Smoked Still Smoke Quit Smoking

How many packs per day did you or do you smoke? _____ How many years?_____

Circle: I want to quit … Now Soon Eventually Never Did Quit? When_____

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13. How Much alcohol do you drink on average? _____

    Do you have concerns about your alcohol use? Yes No

14. Do you currently use recreational drugs? Yes No Marijuana? Yes No Other? _____

    Do you have a history of a prior drug addiction? Yes No

15. How much caffeine do you drink daily (coffee, tea, soda)? _____

16. Please circle or check any of the following that are true for you

Exercise regularly	Smoke detector at home	Do self-breast exam	Eat low fat diet
Fire extinguisher at home	Wear Seatbelt	Gun in home	Gun secured from children
Have a living will	Wear a helmet if biking / roller blading		

17. What are your preferred pronouns? She He They Other:_____

18. What is your sexual orientation Homosexual Heterosexual Bisexual Other:_____

    Do you practice safe sex? Never Sometimes Always

    If needed, what type of birth control method do you use: _____

    Do you have any questions about birth control? Yes No Sexual Functioning? Yes No

Social History:

19. Who lives in your household?_____

    Do you feel safe at home?_____

20. Occupation?_____

    Known hazardous exposures at work?_____

21. Do you have any special concerns that you would like to discuss today?

_____

_____

_____

_____

Thank You!

Reviewed by: _____

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Family Medical History Questionnaire

Date:_____

Name:_____ Date of Birth:_____

Please write in the spaces provided, any **medical conditions** of your family members.

Please include age, if still living, or cause of death and age of death if deceased.

Consider some of the following medical conditions:

High blood pressure	*High cholesterol*	*Heart Attack*
Stroke	*Diabetes*	*Breast Cancer*
Colon Cancer / Polyps	*Other Cancer*	*Asthma*
Seizures	*Drug / Alcohol Abuse*	*Glaucoma*
Thyroid Problems	*Bleeding Disorder*	*Mental Illness*

Mother:_____

_____

Father:_____

_____

Brother(s):_____

_____

Sister(s):_____

_____

Children:_____

_____

Mother's Mother:_____

Mother's Father:_____

Father's Mother:_____

Father's Father:_____

Other:_____

_____

Thank You!

Reviewed by: _____