HARBOUR WOMEN'S HEALTH

OBSTETRICS ● GYNECOLOGY ● UROGYNECOLOGY

Health History Questionnaire - 39 Years Old & Under 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)____________________
   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 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:

When was the last time you had: Physical Exam:_____________

Cholesterol Screening :_____________ Mammogram:_______________

Behaviors and Habits Affecting Health:

11. 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?________________

HARBOUR WOMEN'S HEALTH

OBSTETRICS • GYNECOLOGY • UROGYNECOLOGY

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

12. How Much alcohol do you drink on average? ____

    Do you have concerns about your alcohol use? Yes No

13. Do you currently use recreational drugs? Yes No Marijuana? Yes No Other? _____________

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

14. How much caffeine do you drink daily (coffee, tea, soda)? _______________________________________

15. 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		

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

18. Who lives in your household?____

    Do you feel safe at home?____

19. Occupation?____

    Known hazardous exposures at work?____

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

____

____

____

____

Thank You! Reviewed by: ________________________

HARBOUR WOMEN'S HEALTH

OBSTETRICS • GYNECOLOGY • UROGYNECOLOGY

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: _________________