



PARTNERS IN WOMEN'S HEALTH

PERSONAL AND FAMILY HEALTH HISTORY

The purpose of this questionnaire is to identify any special needs you may have. Your answers will remain confidential.

Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Marital Status: M S D W  
\_\_\_\_\_ Highest Grade Completed \_\_\_\_\_

Social Security # \_\_\_\_\_ Home Telephone # \_\_\_\_\_

Employer \_\_\_\_\_ Work Telephone # \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Telephone # \_\_\_\_\_

Last Menstrual Period \_\_\_\_\_

PLEASE INDICATE BELOW IF YOU OR ANY OF YOUR CLOSE BLOOD RELATIVES HAVE EXPERIENCED ANY OF THE FOLLOWING:

	YOU	FAMILY
High Blood Pressure	_____	_____
Heart Trouble/Heart Attack	_____	_____
Diabetes	_____	_____
Brain Tumor	_____	_____
Seizures	_____	_____
Migraine Headaches	_____	_____
Scoliosis	_____	_____
Thyroid Problems	_____	_____
Adrenal Gland Problems	_____	_____
Pituitary Problems	_____	_____
Cushing's Disease	_____	_____
Bleeding Problems	_____	_____
Chronic Anemia	_____	_____
Sickle Cell Trait/Disease	_____	_____

PLEASE INDICATE BELOW IF YOU HAVE EVER EXPERIENCED OR BEEN TOLD THAT YOU HAVE ANY OF THE FOLLOWING:

	YOU
Rheumatic Fever	_____
Scarlet Fever	_____
Asthma	_____
Bronchitis	_____
Pneumonia	_____
Hiatal Hernia	_____
Ulcers	_____
Gallbladder Problems/Stones	_____
Crohn's Disease	_____

YOU

- Irritable Bowel Syndrome \_\_\_\_\_
- Colitis \_\_\_\_\_
- Heart Murmur \_\_\_\_\_
- Phlebitis \_\_\_\_\_
- Varicose Veins \_\_\_\_\_
- Blood Clots in Legs or Lungs \_\_\_\_\_
- Hepatitis \_\_\_\_\_
- Jaundice \_\_\_\_\_
- Kidney Stones \_\_\_\_\_
- Kidney or Bladder Infection \_\_\_\_\_
- Lymphoma \_\_\_\_\_
- Other Cancer (specify) \_\_\_\_\_
- Mononucleosis \_\_\_\_\_
- Encephalitis \_\_\_\_\_
- Measles \_\_\_\_\_
- Chicken Pox \_\_\_\_\_
- Gonorrhea \_\_\_\_\_
- Chlamydia \_\_\_\_\_
- Trichomoniasis \_\_\_\_\_
- Yeast Infections \_\_\_\_\_
- Herpes: Husband \_\_\_\_\_
- Genital Warts \_\_\_\_\_

USUAL MENSTRUAL CYCLE: LENGTH \_\_\_\_\_

DURATION \_\_\_\_\_ AMOUNT \_\_\_\_\_

ANY IRREGULAR BLEEDING? \_\_\_\_\_

DID YOU HAVE ANY PROBLEMS BECOMING PREGNANT? \_\_\_\_\_

HAVE YOU EVER HAD AN OPERATION? \_\_\_\_\_

YEAR \_\_\_\_\_

PROCEDURE \_\_\_\_\_

HOSPITAL \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

HAVE YOU EVER BEEN HOSPITALIZED? \_\_\_\_\_

YEAR \_\_\_\_\_

DIAGNOSIS \_\_\_\_\_

HAVE YOU EVER HAD ANY SERIOUS ACCIDENTS? \_\_\_\_\_

ARE YOU ALLERGIC TO ANY MEDICINES? (SPECIFY) \_\_\_\_\_

HAVE YOU EVER DONATED BLOOD? \_\_\_\_\_

HAVE YOU EVER BEEN TESTED FOR HIV/AIDS? \_\_\_\_\_

DO YOU SMOKE? \_\_\_\_\_ HOW MUCH BEFORE PREGNANCY? \_\_\_\_\_

SINCE PREGNANCY? \_\_\_\_\_

DO YOU DRINK BEER, WINE, OR HARD LIQUOR? \_\_\_\_\_

DO YOU USE MARIJUANA? \_\_\_\_\_ COCAINE? \_\_\_\_\_ OTHER DRUGS? \_\_\_\_\_

WHAT PRESCRIPTION OR OVER-THE-COUNTER MEDICATIONS DO YOU TAKE REGULARLY? \_\_\_\_\_

DO YOU OWN A CAT? \_\_\_\_\_ DO YOU HANDLE THE KITTY LITTER? \_\_\_\_\_

**PREGNANCY HISTORY:**

No.	YEAR	SEX	WEIGHT	HOURS IN LABOR	PROBLEMS WITH PREGNANCY OR WITH BIRTH (Indicate miscarriages or abortions here)
1					
2					
3					
4					
5					
6					
7					
8					