HEALTH HISTORY UPDATE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.)*:		**Date**	

Marital status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

GYNECOLOGIC HISTORY

Question				
Date of last menstruation:				
Period every ______ days				
Heavy periods, irregularity, spotting, pain, or discharge?	☐	Yes	☐	No
Are you pregnant or breastfeeding?	☐	Yes	☐	No
Any urinary tract, bladder, or kidney infections within the last year?	☐	Yes	☐	No
Any problems with control of urination?	☐	Yes	☐	No
Any hot flashes or sweating at night?	☐	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
Date of last pap smear				
Are you sexually active?	☐	Yes	☐	No
If yes, are you trying for a pregnancy?	☐	Yes	☐	No
Any discomfort with intercourse?	☐	Yes	☐	No
If not trying for a pregnancy list contraceptive or barrier method used:				

Please indicate new or changed conditions or check the box for no changes

PERSONAL HEALTH HISTORY

Medical problems that other doctors have diagnosed ☐ **none**

Recent Surgeries ☐ **none**

Year	Reason	Hospital

Other recent hospitalizations ☐ **none**

Year	Reason	Hospital

FAMILY HEALTH HISTORY

New significant medical problems in your family ☐ **none**

Family member	Condition or illness

List any medications you have started or stopped since your last visit

Name the Drug	Started or stopped	Strength	Frequency Taken

Newly diagnosed 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.						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?		☐	Yes	☐	No
	If yes, are you on a physician prescribed medical diet?		☐	Yes	☐	No
Alcohol	Do you drink alcohol?		☐	Yes	☐	No
	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
	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

SYSTEM REVIEW	
☐ weight gain	☐ frequent urination
☐ weight loss	☐ painful urination
☐ fatigue	☐ palpitations
☐ fever	☐ dizziness
☐ nausea	☐ irregular heartbeat
☐ depression	☐ chest pain
☐ anxiety or panic	☐ leg swelling
☐ high stress level	☐ shortness of breath
☐ headache	☐ cough
☐ sleep disturbance	☐ wheezing
☐ seizures	☐ sinus drainage
☐ abdominal pain	☐ hearing loss
☐ constipation	☐ ringing in ears
☐ heartburn	☐ blurring of vision
☐ diarrhea	☐ diminished vision
☐ bloating	☐ rash
☐ blood in stool	☐ dry or sensitive skin