Health History Questionnaire
Laurel Women's Medical Group

Name: _____ Phone: _____ Date: _____

Age: _____ Birthdate: _____ Date of last period (first day): _____

What is the purpose of your visit today? _____

_____

Gynecology History:

At what age did you get your first period? ……_____

How often do you get your period?..... Every _____ days

How long does your period last?..... days_____

How many pads/tampons do you use on the **heaviest** day? ……. _____

Is there any significant pain with periods? ……	Yes	No
Is there any significant pain at other times of your cycle?.....	Yes	No
Is there any spotting or bleeding after intercourse? ……	Yes	No
Is there any problem with sexual function? ……	Yes	No
Are there any breast masses or lumps? ……	Yes	No
Is there any breast discharge? ……	Yes	No
Are there any urinary complaints? (burning, loss of urine, urgency) ……	Yes	No
Have you ever had an abnormal pap smear result? ……	Yes	No
Have you ever had an abnormal mammogram? ……	Yes	No
Do you have a history of any sexually transmitted infections? ……	Yes	No
Do you have any other problems or concerns not mentioned above? ……	Yes	No

What is your current method of birth control? _____

If you answered yes to any of the above questions, please explain: _____

_____

_____

_____

Obstetrical History- please list all pregnancies, their outcomes and any conditions:

Year	Length of preg.	Vaginal/C-section	Complications
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

General Medical History- please indicate if you have any of the following:

	Anemia		Cancer		Heart failure		Neurologic disorders
	Anesthetic reaction		Type:		Heart murmur		Phlebitis/blood clot
	Angina/chest pain		Depression/anxiety		Hepatitis/liver disease		Seizures/convulsions
	Arthritis		Diabetes		High blood pressure		Skin disorders
	Asthma		Drug dependency		High cholesterol		Stroke/mini-stroke
	Bladder infections		Glaucoma		Irregular heart beat		Thyroid disease
	Bleeding problems		Headaches		Kidney problems		Ulcers
	Blood transfusion		Heart attack		Lung disease		Other:

Family History- please indicate if any family members (parents, grandparents, siblings, children) have the following:

Breast Cancer		Ovarian cancer		Diabetes	
Cervical Cancer		Uterine cancer		Thyroid Disease	
Colon cancer		Other cancer		Heart Disease	
Blood clots		Type:			

Surgical History/Hospitalizations- excluding childbirth

Year	Reason for Hospitalization/Surgery	Any Complications
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication Allergies- please also list the reaction

_____
_____

Current Medications (please include over the counter, strength, frequency and reason for taking)

_____
_____
_____
_____
_____

Personal Habits

Do you smoke? ____ How many per day _____ Do you drink alcohol? _____ How much per week?_____

Do you use recreational drugs?_____ What drugs & how often_____

Do you exercise regularly? _____ Activity & how often _____

Any concerns regarding your visit or health history not covered above please explain below:

_____
_____
_____