

**Harmony Women's Healthcare**

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**HEALTH HISTORY QUESTIONNAIRE**

Date: \_\_\_\_\_ Patient: \_\_\_\_\_

DOB: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Race: \_\_\_\_\_

Date of last complete physical exam: \_\_\_\_\_ Date of last PAP smear : \_\_\_\_\_

First day of last menstrual period: \_\_\_\_\_ Date of last mammogram: \_\_\_\_\_

Name of primary care provider: \_\_\_\_\_

Are you here for your annual well women? YES NO

If no, please describe your current problem(s)? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**OBSTETRIC HISTORY**

How many times in your life have you been pregnant? \_\_\_\_\_

How many full term deliveries have you had? \_\_\_\_\_

How many preterm deliveries have you had? \_\_\_\_\_ (completed 37 weeks gestation)

How many miscarriages have you had? \_\_\_\_\_ (delivered at >20 weeks)

How many ectopic/tubal pregnancies have you had? \_\_\_\_\_

How many abortions/elective terminations have you had? \_\_\_\_\_

Are all of your children living? YES NO

If not, explain: \_\_\_\_\_

Born Mo/Yr	Weight at birth	Sex M/F	Weeks at delivery	Type of delivery	Anesthesia Yes/No	Place of delivery	Preterm labor Yes/No	Complications Yes/No

Patient: \_\_\_\_\_

(continued)

**GYNECOLOGICAL HISTORY**

How old were you when you had your first period? \_\_\_\_\_

Periods are: REGULAR IRREGULAR

On average, how many days are there from the first day of one period to the first day of the next? \_\_\_\_\_

How many days does your period last? \_\_\_\_\_

Do you bleed between periods? YES NO

Do you have painful periods? YES NO If yes, MILD MODERATE SEVERE

Your period is: HEAVY MODERATE LIGHT

When your period is heaviest, how often do you need to change<sup>3</sup> your pad or tampon because it's full or soaked? Every \_\_\_hrs for \_\_\_ days.

Sexually active: YES NEVER NOT NOW (last intercourse was \_\_\_\_\_)

Sexual partners are: MEN WOMEN BOTH

Which of the following methods have you ever used? (CIRCLE)

CONDOMS RHYTHM DIAPHRAGM SPONGE TUBAL LIGATION PATCH NUVA RING IUD PARTNER

HAD VASECTOMY BIRTH CONROL PILLS DEPO PROVERA INJ. \_\_\_\_\_

What form of birth control do you use at the present time? \_\_\_\_\_ or NONE

Do you have a history of the following?:

Herpes? YES NO If yes, last out break \_\_\_\_\_

Trichomonas? YES NO

Human Papilloma Virus (HPV) or genital warts? YES NO

HIV? YES NO

Gonorrhoea? YES NO

Chlamydia? YES NO

Syphillis? YES NO

PID? YES NO

Have you ever had an abnormal pap smear? YES NO

If yes, how old were you when you had the first abnormal pap? \_\_\_\_\_ (age)

How was it treated? \_\_\_\_\_

Have you ever had cryosurgery (freezing of the cervix) YES NO

Do you have a history of endometriosis? YES NO

**MEDICAL HISTORY**

Have you experienced or been diagnosed with any of the following? (Check all that apply)

1. Anemia/Sickle Cell Anemia or trait	2. Arthritis/Bone Disease
3. Asthma	4. Blood Clots in legs or lungs
5. Blood Transfusion	6. Broken Bones
7. Cancer	8. Colitis
9. Depression/Psychiatric Disorder/Anxiety	10. Diabetes
11. Emphysema/Bronchitis	12. Gallbladder Disease/Stones/Infection
13. Hepatitis/Yellow Jaundice	14. High Blood Pressure
15. Leukemia	16. Migraines
17. Nervous Breakdown/Mental Problems	18. Phlebitis
19. Heart Problems/Angina	20. Seizures
21. Stomach Ulcers	22. Thyroid Disorder
23. Chicken Pox	

Other: \_\_\_\_\_

Patient: \_\_\_\_\_

(continued)

List all present medications and doses including any over the counter or herbal meds:

\_\_\_\_\_  
\_\_\_\_\_

Are you allergic to any drugs? YES NO (List drug and reaction) :

\_\_\_\_\_  
\_\_\_\_\_

Do have an allergy to latex? YES NO

### SURGICAL HISTORY

Have you had any surgeries? YES NO

(Check and include surgery date)

1. Appendectomy	2. Bladder Surgery
3. Bone Surgery	4. C-Section
5. D & C	6. Gallbladder Removal
7. Head/Neck Surgery	8. Heart/ Lung Surgery
9. Hysterectomy with/without removal of ovaries	10. Laparoscopy
11. Surgery of fallopian tubes or ovaries	12. Tonsillectomy

Details/Other: \_\_\_\_\_  
\_\_\_\_\_

### SOCIAL HISTORY

Do you or have you ever smoked? YES NO If yes, how much? \_\_\_\_\_

What age did you start smoking? \_\_\_\_\_ or when did you quit? \_\_\_\_\_

How much alcohol do you consume weekly? \_\_\_\_\_

Do you or have you ever used illicit or recreational drugs? YES NO

If yes, last use? \_\_\_\_\_ Type(s): \_\_\_\_\_

What kind of work do you do? \_\_\_\_\_

You are: MARRIED SINGLE DIVORCED WIDOW

### FAMILY HISTORY

Mother: Living Deceased (cause) \_\_\_\_\_ Age: \_\_\_\_\_

Mother's major medical problems: \_\_\_\_\_ Age: \_\_\_\_\_

Father: Living Deceased (cause) \_\_\_\_\_ Age: \_\_\_\_\_

Father's major medical problems: \_\_\_\_\_ Age: \_\_\_\_\_

Siblings: Number Living \_\_\_\_\_ Number Deceased \_\_\_\_\_ (cause) \_\_\_\_\_ Age: \_\_\_\_\_

Siblings' major medical problems: \_\_\_\_\_

Children: Number Living \_\_\_\_\_ Number Deceased \_\_\_\_\_ (cause) \_\_\_\_\_ Age: \_\_\_\_\_

Children's major medical problems: \_\_\_\_\_

Has any blood relative had any of the following? :

Breast Cancer? YES NO \_\_\_\_\_

Colon Cancer? YES NO \_\_\_\_\_

Ovarian Cancer? YES NO \_\_\_\_\_

Do any genetic/inherited disorders run in your family? YES NO

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

# Harmony Women's Healthcare

## Appointment Worksheet

Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Last Menstrual Period: \_\_\_\_\_ Normal? YES NO \_\_\_\_\_

**PLEASE CHECK IF YOU HAVE OR HAD ANY OF THE FOLLOWING:**

SYMPTOM	IN THE PAST	NOW	SYMPTOM	IN THE PAST	NOW	SYMPTOM	IN THE PAST	NOW
1. Severe Headaches			16.Ulcers			31. Very heavy menstrual periods		
2. Glasses			17.Heartburn			32.Breast biopsy		
3. Glaucoma			18.Severe abdominal pain			33.Pelvic Infection		
4. Serious ear problem			19.Diarrhea			34.Trouble with sex		
5. Dentures			20.Black Stool			35. Abnormal pap smear		
6. Difficulty swallowing			21.Hemorrhoids			36.Excessive weight loss/gain		
7. High Blood Pressure			22.Gall bladder disease			37.Diabetes		
8. Heart Disease			23.Change in bowel habits			38.Thyroid trouble		
9. Shortness of breathe			24.Buring on urination			39.Psychiatric care		
10.Chest Pain			25.Urinating 3 or more times a night			40.Severe depression		
11.Excessive			26.Loss of urine when coughing			41.Blood clots in veins/lungs		
12.Asthma			27.Blood in urine			42.Convulsions		
13.Coughing up blood			28.Veneral disease (GC, herpes, etc.)			43.Painful joints		
14.Palpations			29.Bothersome vaginal disease			44.Leg Cramps		
15.Prolonged nausea/vomiting			30.Very painful periods			45.Broken Bones		

Any medications you are currently using? \_\_\_\_\_

Allergies to medications? \_\_\_\_\_

Further history? \_\_\_\_\_

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Physical Exam vs. BP \_\_\_\_\_ WT \_\_\_\_\_ HT \_\_\_\_\_ U/A \_\_\_\_\_

Further history by nurse or doctor: \_\_\_\_\_