Personal Health History Questionnaire

MY PERSONAL MEDICAL HISTORY

Name: _____ Height:_____

Date of Birth:_____ Weight:_____

Race

[ ] Caucasian [ ] Asian [ ] African-American [ ] American Indian

[ ] Hispanic [ ] Other:

Infectious Diseases

Check any of the following diseases that you have had:

[ ] Measles (hard, seven-day, Rubeola)M

[ ] German measles (three-day, Rubella)

[ ] Mumps

[ ] Hepatitis A (usually from contaminated food)

[ ] Hepatitis B (usually transmitted by contaminated blood or sexually)

[ ] Hepatitis C (usually transmitted by contaminated blood or sexually)

[ ] HIV (the virus that causes AIDS)

[ ] Tuberculosis

[ ] Rheumatic fever

[ ] Polio

[ ] Gonorrhea

[ ] Chlamydia

[ ] Herpes

[ ] Syphilis

[ ] Condyloma (genital warts)

Surgery

Please list all the surgeries that you have had:

_____
_____
_____
_____

Menstrual History

What age were you when your periods started?_____

How many days does your period usually last?_____

How many days are between your periods?_____

How many pads or tampons do you use on a heavy day? _____

How much pain do you have with your periods?_____

[ ] Mild

[ ] Moderate

[ ] Severe

Has there been a change in the amount of pain you have?

[ ] Yes

[ ] No

Gynecologic History

When was your last pap test?_____

Have you ever had an abnormal pap test?

[ ] Yes [ ] No

If yes, did you have any of the following treatments? (See Glossary for definitions).

[ ] Cryo (freezing of your cervix)

[ ] Leep (removal of part of your cervix by electric cautery)

[ ] Conization (removal of part of cervix surgically in hospital)

[ ] Hysterectomy (removal of uterus only)

Check any of the following vaginal problems you have:

[ ] Discharge

[ ] Itching

[ ] Burning

[ ] Odor

[ ] Pain with intercourse

[ ] Dryness or inability to lubricate

[ ] Sores

[ ] Growths

Has your mother or a sister had cancer of any of the following:

[ ] Uterus

[ ] Ovaries

[ ] Vagina

[ ] Fallopian tubes

Contraceptive History

Check any of the following birth control methods you have used:

[ ] Birth control pills

[ ] Patch

[ ] Vaginal ring

[ ] IUD (intrauterine device)

[ ] Diaphragm

[ ] Cervical cap

[ ] Sponge

[ ] Spermicide

[ ] Norplant

[ ] Depo Provera

[ ] Natural family planning

[ ] Tubal Ligation

Pregnancy History

How many times have you been pregnant? _____

How many live births have you had? _____

How many miscarriages have you had? _____

How many abortions have you had? _____

Have you had any of the following complications with pregnancy?

[ ] High blood pressure

[ ] Diabetes

Sexual History

What age were you when you had intercourse the first time?_____

Are you currently sexually active?

[ ] Yes

[ ] No

If yes, check any of the following that apply to you:

[ ] I am satisfied with my sex life.

[ ] I have orgasms.

[ ] I have pain with intercourse.

[ ] I have decreased sexual desire.

Have you ever been touched in a sexual way that made you uncomfortable? If yes, have you ever spoken to anyone about it?

[ ] Yes

[ ] No

If you had a professional person with whom you felt comfortable, would you be willing to discuss this?

[ ] Yes

[ ] No

Breast History

Do you do self-breast exams?

[ ] Yes

[ ] No

If yes, how often do you do them? _____

If no, why not? _____

Have you had a mammogram?

[ ] Yes

[ ] No

If yes, when? _____

If no, why not? _____

Has your mother or a sister had breast cancer?

[ ] Yes

[ ] No

Do you have any lumps in your breasts that you feel are new?

[ ] Yes

[ ] No

Have you had any discharge from your nipples?

[ ] Yes

[ ] No

If yes, what was the color of the discharge?

[ ] White

[ ] Clear

[ ] Red

[ ] Brown

[ ] Black

[ ] Green

Do you have any breast pain?

[ ] Yes

[ ] No

Nutrition History

Do you drink alcohol?

[ ] Yes

[ ] No

If yes, how much per day?_____ ounces

(There is one ounce of alcohol in one 12 oz. beer, 6 oz. wine, or 2 oz. 100-proof liquor.)

Do you drink carbonated beverages?

[ ] Yes

[ ] No

If yes, how much per day? _____ cans/bottles

Do you drink coffee?

[ ] Yes

[ ] No

If yes, how much per day? _____ cups

How many servings of dairy products do you eat each day?_____servings

How many servings of meat products do you eat each day? _____servings

How many servings of fruits and vegetables do you eat each day?_____servings

How many servings of grain products do you eat each day? _____servings

Do you eat chocolate?

[ ] Yes

[ ] No

Cardiovascular History

Have you ever had high blood pressure?

[ ] Yes

[ ] No

Have you taken medication for high blood pressure?

[ ] Yes

[ ] No

Have you ever had blood clots in your veins or arteries?

[ ] Yes

[ ] No

Have you ever had a heart attack?

[ ] Yes

[ ] No

Has anyone related to you ever had a heart attack?

[ ] Yes

[ ] No

If yes, what relation were they to you? _____

At what age did it happen to them? _____

Have you ever smoked cigarettes?

[ ] Yes

[ ] No

Do you smoke cigarettes now?

[ ] Yes

[ ] No

If yes, how many per day? _____

Would you consider quitting?

Do you get regular physical exercise?

[ ] Yes

[ ] No

If yes, please describe: _____

If no, what keeps you from exercising? _____

Bladder History

Do you have trouble emptying your bladder?

[ ] Yes

[ ] No

Do you lose urine when you cough, sneeze, or run?

[ ] Yes

[ ] No

Do you lose urine on the way to the toilet?

[ ] Yes

[ ] No

Have you had bladder infections?

[ ] Yes

[ ] No

Do you empty your bladder more than 10 times a day?

[ ] Yes

[ ] No

Bowel History

Do you have constipation?

[ ] Yes

[ ] No

Do you have frequent diarrhea?

[ ] Yes

[ ] No

Do you have trouble with hemorrhoids?

[ ] Yes

[ ] No

Do you have relatives with bowel or colon cancer?

[ ] Yes

[ ] No

Have you noticed blood with your bowel movements?

[ ] Yes

[ ] No

Have you had tests for blood in your bowel movements?

[ ] Yes

[ ] No

If you are over 50, have you had a sigmoidoscopy or colonoscopy?

[ ] Yes

[ ] No

Emotional History

Check any of the following that you have experienced:

[ ] Crying often

[ ] Feeling depressed for more than two weeks

[ ] Feeling like you want to die

[ ] Feeling helpless

[ ] Feeling hopeless

[ ] Feeling "trapped"

[ ] Wanting to be alone most of the time

[ ] Feeling guilty

[ ] Feeling like a failure

[ ] Waking up early (before you want to)

[ ] Difficulty falling asleep

[ ] Feeling nervous most of the time

[ ] Worrying most of the time

Has anyone closely related to you suffered with emotional health problems?

[ ] Yes

[ ] No

Write a sentence about how you feel most of the time:

Social History

Describe your occupation: _____

How many years of schooling have you had? _____years

Would you like to have more education?

[ ] Yes

[ ] No

If yes, what keeps you from going back to school?

Are you:

[ ] Single

[ ] Married

[ ] Widowed

[ ] Divorced

Are you happy with your marital status?

[ ] Yes

[ ] No

Domestic violence occurs in many relationships and may cause terrible injury, both physical and emotional.

Have you ever been physically or emotionally abused by someone with whom you had a close relationship?

[ ] Yes

[ ] No

If yes, have you discussed this with a professional?

[ ] Yes

[ ] No

If you do not have someone with whom you feel you can discuss an abuse problem, please refer to the agencies listed in the Resource section in the back of your Personal Healthcare Plan.

Is there anything else you would like your healthcare provider to know about you and your health?