



BALANCED
HEALTH
Center

HEALTH HISTORY QUESTIONNAIRE

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

Original Date:
Dates Reviewed:

Name <i>(Last, First, M.I.):</i>		DOB:
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Referred by:
Occupation:		Spouse/Partners name:
Gynecologist:	Date of last exam:	Mammogram:

PERSONAL HEALTH HISTORY

General Health:	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor		
Childhood illness:	<input type="checkbox"/> Measles	<input type="checkbox"/> Mumps	<input type="checkbox"/> Rubella	<input type="checkbox"/> Chickenpox	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Polio
Immunizations and dates:	<input type="checkbox"/> HPV		<input type="checkbox"/> Influenza			
	<input type="checkbox"/> Hepatitis B		<input type="checkbox"/> Chickenpox			
	<input type="checkbox"/> Hepatitis A		<input type="checkbox"/> MMR <i>Measles, Mumps, Rubella</i>			

Have you had any of the following medical conditions:

Asthma	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	Neurological Disorder	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	Stroke	<input type="checkbox"/>
Depression/anxiety disorder	<input type="checkbox"/>	IBS	<input type="checkbox"/>	Substance abuse	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Mitral valve prolapse	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>
Eating disorder	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	Vascular disease	<input type="checkbox"/>

Other Illnesses or Hospitalizations

Year	Type	Physican/Hospital Treatment

Hospitalizations (other than above surgeries or childbirth)

Year	Reason	Hospital

Have you ever had a blood transfusion?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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List your supplements (vitamins, herbs, remedies), prescribed drugs or any over-the-counter drugs you take regularly

Name	Strength	Frequency Taken

Allergies to medications/foods/other

Medication/item	Reaction You Had

Allergy to Latex? Yes No

HEALTH HABITS AND PERSONAL SAFETY

Exercise	<input type="checkbox"/> Sedentary (No exercise)				
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Diet	Are you on a special diet?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	If yes, are you on a prescribed medical diet?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	# of meals you eat in an average day?	How many snacks in an average day?			
Caffeine	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Cola	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	How many drinks per week?				
Tobacco	Do you use tobacco?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> # of years	<input type="checkbox"/> Year Quit		
	Does anyone at home smoke?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Drugs	Do you currently use recreational drugs?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Sexual Activity	Are you sexually active?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gender of Partner	<input type="checkbox"/> Male <input type="checkbox"/> Female	
	Lifetime total number of sexual partners		Do you practice safe sex?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Current birth control:		How Long?		
	Any problems with birth control?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Any discomfort with intercourse?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Personal Safety	Do you live alone?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Have you ever been abused, threatened or hurt by anyone?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Do you wear your seatbelt?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS	DECEASED	AGE	SIGNIFICANT HEALTH PROBLEMS
Father			<input type="checkbox"/>	Children	<input type="checkbox"/> M <input type="checkbox"/> F
Mother			<input type="checkbox"/>		<input type="checkbox"/> M <input type="checkbox"/> F
Grandmother <i>Maternal</i>			<input type="checkbox"/>		<input type="checkbox"/> M <input type="checkbox"/> F
Grandfather <i>Maternal</i>			<input type="checkbox"/>	Siblings	<input type="checkbox"/> M <input type="checkbox"/> F
Grandmother <i>Paternal</i>			<input type="checkbox"/>		<input type="checkbox"/> M <input type="checkbox"/> F
Grandfather <i>Paternal</i>			<input type="checkbox"/>		<input type="checkbox"/> M <input type="checkbox"/> F

GYNECOLOGICAL HISTORY

Age at onset of menstruation:				Date of last menstruation:					
Period every ____ days									
Heavy periods, irregularity, spotting, pain, or discharge?							<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you ever been pregnant?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	How many times?					
Miscarriage		<input type="checkbox"/> Yes	<input type="checkbox"/> No	When?		Ectopic	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When?
Terminations		<input type="checkbox"/> Yes	<input type="checkbox"/> No	When?					
Live Births		<input type="checkbox"/> Vaginal	<input type="checkbox"/> C-Section	Number of living children					
Are you pregnant or breastfeeding?							<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Any urinary tract, bladder, or kidney infections within the last year?							<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Any blood in your urine?							<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Any problems with control of urination?							<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Any hot flashes or sweating at night?							<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?							<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you perform breast self-examination?							<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Recent breast tenderness, lumps, or nipple discharge?							<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Date of last pap:				Date of last mammogram:					
Abnormal pap smear?		When?		Treatment?		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Have you ever been treated for a sexually transmitted disease?							<input type="checkbox"/> Yes	<input type="checkbox"/> No	

OTHER PROBLEMS

Check if you have had any of the following symptoms currently or within the last 6 months:

<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Constipation	<input type="checkbox"/> Pelvic Pain
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression	<input type="checkbox"/> Rectal bleeding
<input type="checkbox"/> Appetite change	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Weight loss/gain
<input type="checkbox"/> Bladder changes	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Other
<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Headaches	<input type="checkbox"/>
<input type="checkbox"/> Chest pain/palpitations	<input type="checkbox"/> Heartburn	<input type="checkbox"/>