



PARTNERS IN WOMEN'S HEALTH

PERSONAL AND FAMILY HEALTH HISTORY

The purpose of this questionnaire is to identify any special needs you may have.
Your answers will remain confidential.

Name _____ Age _____ Date of Birth _____

Address _____ Marital Status: M S D W
_____ Highest Grade Completed _____

Social Security # _____ Home Telephone # _____

Employer _____ Work Telephone # _____

Emergency Contact _____ Telephone # _____

Last Menstrual Period _____

PLEASE INDICATE BELOW IF YOU OR ANY OF YOUR CLOSE BLOOD RELATIVES HAVE EXPERIENCED ANY OF THE FOLLOWING:

	YOU	FAMILY
High Blood Pressure	_____	_____
Heart Trouble/Heart Attack	_____	_____
Diabetes	_____	_____
Brain Tumor	_____	_____
Seizures	_____	_____
Migraine Headaches	_____	_____
Scoliosis	_____	_____
Thyroid Problems	_____	_____
Adrenal Gland Problems	_____	_____
Pituitary Problems	_____	_____
Cushing's Disease	_____	_____
Bleeding Problems	_____	_____
Chronic Anemia	_____	_____
Sickle Cell Trait/Disease	_____	_____

PLEASE INDICATE BELOW IF YOU HAVE EVER EXPERIENCED OR BEEN TOLD THAT YOU HAVE ANY OF THE FOLLOWING:

	YOU
Rheumatic Fever	_____
Scarlet Fever	_____
Asthma	_____
Bronchitis	_____
Pneumonia	_____
Hiatal Hernia	_____
Ulcers	_____
Gallbladder Problems/Stones	_____
Crohn's Disease	_____

YOU

Irritable Bowel Syndrome _____
Colitis _____
Heart Murmur _____
Phlebitis _____
Varicose Veins _____
Blood Clots in Legs or Lungs _____
Hepatitis _____
Jaundice _____
Kidney Stones _____
Kidney or Bladder Infection _____
Lymphoma _____
Other Cancer (specify) _____
Mononucleosis _____
Encephalitis _____
Measles _____
Chicken Pox _____
Gonorrhea _____
Chlamydia _____
Trichomoniasis _____
Yeast Infections _____
Herpes: Husband _____
Genital Warts _____

USUAL MENSTRUAL CYCLE: LENGTH _____

DURATION _____ AMOUNT _____

ANY IRREGULAR BLEEDING? _____

DID YOU HAVE ANY PROBLEMS BECOMING PREGNANT? _____

HAVE YOU EVER HAD AN OPERATION? _____

YEAR _____

PROCEDURE _____

HOSPITAL _____

PHYSICIAN _____

HAVE YOU EVER BEEN HOSPITALIZED? _____

YEAR _____

DIAGNOSIS _____

HAVE YOU EVER HAD ANY SERIOUS ACCIDENTS? _____

ARE YOU ALLERGIC TO ANY MEDICINES? (SPECIFY) _____

HAVE YOU EVER DONATED BLOOD? _____

HAVE YOU EVER BEEN TESTED FOR HIV/AIDS? _____

DO YOU SMOKE? _____ HOW MUCH BEFORE PREGNANCY? _____

SINCE PREGNANCY? _____

DO YOU DRINK BEER, WINE, OR HARD LIQUOR? _____

DO YOU USE MARIJUANA? _____ COCAINE? _____ OTHER DRUGS? _____

WHAT PRESCRIPTION OR OVER-THE-COUNTER MEDICATIONS DO YOU TAKE REGULARLY? _____

DO YOU OWN A CAT? _____ DO YOU HANDLE THE KITTY LITTER? _____

PREGNANCY HISTORY:

No.	YEAR	SEX	WEIGHT	HOURS IN LABOR	PROBLEMS WITH PREGNANCY OR WITH BIRTH (Indicate miscarriages or abortions here)
1					
2					
3					
4					
5					
6					
7					
8					