

Overlake Obstetricians and Gynecologists, PC

Health History Questionnaire

Last Name: _____

First Name: _____

Birth Date: _____

Today's Date: _____

What name do you wish to be called? _____

Previous Hospitalizations, Surgery, Serious Injury

Type	Year

Date of last Dexa/Bone Scan _____

Date of last mammogram _____

Date of last pap _____

First day of last menstrual period _____

Usual interval between periods _____

How long do your periods last _____

Current Medications

Name	Dose

Are your periods painful Yes No

Is there bleeding between periods Yes No

Number of pregnancies _____

Number of children _____

Have you had difficulty becoming pregnant Yes No

Do you use any birth control method Yes No

If so, what type _____

List other forms you have used _____

Are you satisfied with your birth control Yes No

Is there any aspect of your sexuality or a problem you wish to discuss Yes No

Do you have any abnormal vaginal discharge Yes No

Have you had an infection in your tubes or ovaries Yes No

Have you ever had an abnormal pap smear Yes No

Have you ever had genital warts Yes No

Have you ever had genital herpes Yes No

Drug Allergies Yes No

Past or Present Illness

Diabetes	Yes	No
Thyroid	Yes	No
High blood pressure	Yes	No
Heart disease or murmur	Yes	No
Migraine headaches	Yes	No
Respiratory problems/Asthma	Yes	No
Stomach or bowel problems	Yes	No
Hepatitis	Yes	No
Blood transfusions	Yes	No
Bladder infections	Yes	No
Uncontrolled loss of urine	Yes	No
Easy bruising / nosebleeds / bleeding disorders	Yes	No
Deep vein thrombosis	Yes	No
Pulmonary embolus	Yes	No

Family History

Relation to You

Diabetes	_____
Heart disease	_____
High blood pressure	_____
Genital cancer	_____
Breast cancer	_____
Bleeding problems	_____
Multiplebirths (twins, triplets)	_____
Birth defects or hereditary disease	_____
Osteoporosis	_____

Do You Use

Cigarettes	Yes	No	Amt / Day	_____
Alcohol	Yes	No	Amt / Day	_____
Caffeine	Yes	No	Amt / Day	_____

Do you prefer to have a nurse present when the doctor examines you? Yes No