Personal Health History Questionnaire

Date:_____________________________ Contact Information:
Name:____________________________ ****Email______________________________
Age:_____________________________ Phone____________________________
Health Card & version code: _______________________ Mail ____ Yes ____ No
How did you hear about the Women's Health Centre? _____________________________________

Medical History:
List your allergies: Drug ____
Food ____
Environmental ____

List your medication & supplements including dose (prescription & over-the-counter):

Medication	DOSE	**Supplements**	DOSE

List any tests done in the past 2 years, date & location (X-ray, U/S, ECG, Mammogram, Pap, blood)
____

Infectious Disease: Have you had any of the following?
____ Measles (Rubeola) ____ German Measles (Rubella) ____ Mumps ____ Polio
____ Rheumatic Fever ____ Chicken Pox (Varicella) ____ Tuberculosis
____ Hepatitis A ____ Hepatitis B ____ Hepatitis C
____ Chlamydia ____ Gonorrhea ____ Syphilis
____ Herpes ____ Genital Warts ____ HIV

Surgical History (indicate year, type of surgery, reason for):

YEAR	SURGERY	REASON

Cardiovascular History:
Have you ever had high blood pressure? ____ No ____ Yes – when diagnosed? __________________
Have you ever taken medication for high blood pressure? ____ No _____ Yes – name______________
Have you ever had blood clots? ____ No ____ Yes – where? ______________________________
Have you ever had a heart attack? ____ No ____ Yes – when? ______________________________
Has anyone related to you ever had a heart attack? ____ No ____ Yes – who? __________ age ______
How often do you exercise each week?

Type of Activity	**# of hours / week**

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Breast History:

How often do you do Breast self exams? ____ monthly ____ X/year ____ Never-why? ____________

Has your mother (M) or sister (S) had breast cancer? ____ No ____ Yes (indicate M, S-how many)

Do you have any new lumps in your breast? ____ No ____ Yes - for how long ____

Have you had any discharge from your nipples? ____No ___Yes – (circle)white, clear, red, brown, green

Do you have breast pain? ____ No ____ Yes – describe____

when___ before periods___during periods___all the time

Menstrual History:

Date of your last menstrual period. _________________

What age were you when your periods started? ____

How many days does your period usually last? ____

How many days between your period? ____

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? ____________________________________

Gynecologic History:

When was your last PAP test? ________________

Have you ever had an abnormal PAP test? NO ____ YES____ when _________ & how was it treated?

____

Check any of the following vaginal problems you experience (now or previously):

____ discharge (circle: curdley, white, thick, yellow, green, thin, brown, itchy, burning, odour)

____ pain with intercourse ____ dryness or inability to lubricate ____ sores – describe _____________

Has your mother (M) or sister(S) had CANCER of any of the following?

Identify with M or S ____ uterus ____ ovaries ____ vagina ____ fallopian tubes

Sexual History:

What age were you when you had intercourse for the first time? ____

Are you currently sexually active now?____NO ____ YES- heterosexual____lesbian____bisexual____

Check any that apply to you:

____ I am satisfied with my sex life. ____ I have decreased sexual desire

____ I have orgasms ____ None ____ I have pain with intercourse

Have you ever been touched in a sexual way that made you uncomfortable? ____ No ____ Yes – Have you discussed this with anyone? ____ No ____ Yes – with whom _____________________

Would you like to discuss this with us? ____ No ____ Yes

Contraceptive History:

Check any of the following birth control methods you have used: ____ Natural Family Planning

____ birth control pills	____ Condoms	____ vasectomy	____ tubal ligation
____ diaphragm	____ cervical cap	____ sponge	____ spermicide
____ IUD (intrauterine device)	____ Norplant	____ Mirena	____ Depo Provera

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? ____

What complications have you had during your pregnancy? ____ high blood pressure ____ diabetes

Other:____

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Bowel History:

How often are you constipated? ____ Never ____ /day ____ /week ____ /month – take____________
How often do you have diarrhea? ____ Never ____/day ____ /week ____ /month – take____________
Do you see blood on your bowel movements? ____ No ____ Yes – how often? ____ daily ____ / mo.
Do you have hemorrhoids? ____ No ____ Yes - take____________________________________
Do your relatives have bowel or colon cancer? ____ No ____ Yes – who ______________ age ____
Have you ever had a colonoscopy? ____ No ____ Yes – when & where ______________________

Bladder History:

Do you have trouble emptying your bladder? ____No ____ Yes – how long ____________________
Do you lose urine when you cough, sneeze, run, laugh etc.? ____No ____Yes
Do you lose urine on the way to the bathroom? ____No ____Yes
Number of bladder infections in the past year: ____ #____ None

Emotional History:

Circle any of the following that you are feeling now:

Excessive crying Depression Anxiety Troubles with Sleeping

What would you like to change?
____

Has anyone close to you had emotional health problems? ____ No ____ Yes – who? ___________________
Write a sentence about how you feel most of the time
____
____

How do you cope with stress?
____
____

Social History:

Occupation____
Level of school completed ____
Are you: ____ single ____ married ____ common-law ____ widowed ____ divorced
Are you happy with your marital status? ____ Yes ____ No – safe ____ Yes ____ No
Has someone ever physically or emotionally abused you? ____ No ____ Yes – who have you discussed this with? ____
Would you like to discuss it with us? ____ No ____ Yes – who would you like to discuss this with?
____

Circle & complete those that apply to you:
Alcohol Caffeine Cannabis Tobacco Drugs ___________________________
Have you ever smoked cigarettes? ____ No ____ Yes – Now? ____ No – Quit after ____ years.
____ Yes – how much? ____/day
How much alcohol do you drink? ____

Do you have specific health concerns?
____
____
____

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________THIS SECTION to be filled out with your HEALTH CARE PROFESSIONAL_______

Family History:
(immediate family only: include mother, father, sisters & brothers)

MOTHER **FATHER**

Synopsis of Health Concerns	
1.	2.
3.	4.
5.	6.
7.	8.
9.	10.

(adapted from: Woman Care. Karen Lee's Virtual Clinic. 1996 Karen Lee, A.R.N.P.)
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