Park East Gynecology & Surgery, PC
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HEALTH HISTORY QUESTIONNAIRE

Please print and complete the following details. Please bring this completed form to your initial consult. Should you require assistance with completion of this data, please do not hesitate to contact our offices.

Full Name:

Date of Birth:

Complete Mailing Address:

Contact Numbers: Home # Work # Mobile #

Marital status (circle one): Single / Mar / Div / Sep / Wid / Other

PERSONAL HEALTH HISTORY

Please indicate "yes" or "no" if you had, or currently experience, any of the following:

_____ Heart Trouble	_____ Ovarian Cancer
_____ High Blood Pressure	_____ Cervical Cancer
_____ Diabetes	_____ Breast Cancer
_____ Anemia	_____ Abnormal Pap Smear
_____ Breast Disorder	_____ Thyroid Disease
_____ Ulcer Disease	_____ Varicose Veins
_____ Respiratory	_____ Gallbladder
_____ Urinary	_____ Headaches
_____ Circulatory	_____ Hepatitis
_____ Nervous System	_____ Kidney/Renal Problems

LIST ANY MEDICAL PROBLEMS THAT OTHER DOCTORS MAY HAVE DIAGNOSED:

PAST SURGICAL HISTORY

Year	Reason	Hospital

MENSTRUAL HISTORY
Please complete to the best of your ability and knowledge.

Age at onset of menstruation:				
Date of last menstruation:				
Period every _____ days				
Heavy periods, irregularity, spotting, pain, or discharge?	☐	Yes	☐	No
Number of pregnancies _____ Number of live births _____				
Are you pregnant or breastfeeding now, or did you breastfeed in the past?	☐	Yes	☐	No
Have you had a D&C, hysterectomy, or Cesarean?	☐	Yes	☐	No
Any urinary tract, bladder, or kidney infections within the last year?	☐	Yes	☐	No
Any blood in your urine?	☐	Yes	☐	No
Any problems with control of urination?	☐	Yes	☐	No
Any problems with bowels, such bloody stool, painful movements or urgency?	☐	Yes	☐	No
Any hot flashes or sweating at night?	☐	Yes	☐	No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐	Yes	☐	No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐	Yes	☐	No
Date of last pap and rectal exam?				

FAMILY HISTORY
Is there a family history of…

Heart Trouble? _____ If so, whom (relationship to you)? _____
Diabetes? _____ If so, whom (relationship to you)? _____
Cancer? _____ If so, of what origin? _____ If so, whom (relationship to you)? _____

MEDICATION LISTING
Please list your prescribed and over-the-counter drugs including supplements, vitamins, inhalers, etc.

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had

HEALTH HABITS & PERSONAL SAFETY

AS A REMINDER, ALL QUESTIONS CONTAINED IN THIS DOCUMENT ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to "binge" drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No
Sex	Are you sexually active?				☐ Yes	☐ No
	If yes, are you trying for a pregnancy?				☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:					
	Any discomfort with intercourse?				☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?				☐ Yes	☐ No
Personal Safety	Do you live alone?				☐ Yes	☐ No
	Physical and/or mental abuse has also become a major public health issue in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?				☐ Yes	☐ No

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

If you would like to note further detail, please feel free to utilize the space below.
Thank you for taking the time to complete this form in order to facilitate our treatment of your case.