

CONFIDENTIAL HEALTH HISTORY QUESTIONNAIRE

To be completed by the patient.

Patient Label

SEXUAL AND REPRODUCTIVE HEALTH

QUESTION FOR WOMEN ONLY:

MENSTRUATION: Age Periods Began: _____ Total Number: _____
 Cycle Length: _____ Full Term: _____
 Period Length: _____ Premature: _____
 Last Menstrual Period: _____ Stillbirth: _____

FLOW
 Heavy Medium Light

DISCOMFORT:
 Severe Moderate Mild

PMS (Pre-Menstrual Syndrome)
 Yes No

PREGNANCIES:
 Total Number: _____
 Full Term: _____
 Premature: _____
 Stillbirth: _____
 Miscarriages: _____
 Abortions: _____
 Tubal Pregnancy: _____

PREGNANCY COMPLICATIONS:

QUESTION FOR BOTH MEN AND WOMEN:

Do you use a form of birth control? No Yes If Yes, what kind(s) _____

Have you ever had any sexually transmitted diseases? No Yes
 If Yes, what kind(s) _____

How would you describe your sexual orientation?

Do you have any questions or problems in regard to your sex life?

Do you have any concerns about your fertility? No Yes
 What type of concerns _____

PERSONAL HISTORY

MARITAL HISTORY:

My current status is: Married Single Widowed Divorced
 With whom do you now live? _____

EDUCATION & OCCUPATION:

Highest education achieved? _____
 Present position / employment? _____
 Previous job? _____
 Exposure to toxins at work? No Yes - Type? _____
 Do you have current vocational concerns? No Yes If so, please list

RELIGION:

Religious preference: _____
 Church Affiliation: _____
 Do you have any specific cultural needs? No Yes
 If Yes, explain: _____

SPECIAL NEEDS:

Do you have a developmental disability? No Yes
 If Yes, describe: _____

Will you require special assistance during your visit? No Yes
 What type? _____

DIET, EXERCISE, & HABITS:

Do you follow a special diet? _____
 Weight? Current: _____ Desired: _____ 1 year ago: _____
 Exercise? What kind of exercise do you do? _____

PAIN

Do you have physical pain? No Yes
 If yes, on scale from 1 - 10 (10 worst) how is it now? _____
 Cause of pain if present: _____

TOBACCO USE:

How much do you smoke? None Regularly, _____ / per day
 Have you quit smoking? No Yes - When? _____
 Do you use any other tobacco? No Yes - What? _____

ALCOHOL USE:

Do you drink alcohol? No Yes
 Have you had any problems with your drinking? No Yes
 If Yes, please explain: _____

What is your drinking pattern? _____

Do you use recreational drugs? No Yes
 What type? _____

LEGAL:

Do you have any current legal issues pending? No Yes
 If Yes, describe: _____

Past convictions? No Yes If Yes, describe: _____

VIOLENCE / ABUSE:

Is violence at home or work a concern for you? No Yes
 If Yes, describe: _____

Have you ever been abused? No Yes
 By whom: _____

 Patient Signature Date

 Provider Review / Signature Date