Camelback Women's Health

Patient Health History Questionnaire

Patient Name:	Date of Birth:

What is the reason you're being seen today?

MEDICATION ALLERGIES □ **NO KNOWN DRUG ALLERGIES**

Name: _____ Type of reaction: _____

Name: _____ Type of reaction: _____

Name: _____ Type of reaction: _____

CURRENT MEDICATIONS □ **NONE**

Name: _____ Mgs/units: _____ How often? _____

Name: _____ Mgs/units: _____ How often? _____

Name: _____ Mgs/units: _____ How often? _____

Name: _____ Mgs/units: _____ How often? _____

Name: _____ Mgs/units: _____ How often? _____

VACCINES □ **NONE**

☐ HPV/Gardasil Date: _____

☐ Tdap Date: _____

☐ Influenza Date: _____

ACTIVE/CURRENT HEALTH PROBLEMS □ **NONE**

1.) _____ Onset Date: _____

2.) _____ Onset Date: _____

3.) _____ Onset Date: _____

4.) _____ Onset Date: _____

GYNECOLOGICAL HISTORY

Date of last Pap Smear	
Date of last HPV testing	
History of abnormal pap	□ Yes
History of HPV	□ Yes
Date of last mammogram	
Date of last colonoscopy	
Date of last bone density	
Date of last cholesterol test	
Date of last diabetes screen	
History of cervical dysplasia	□ Yes
History of vulvar dysplasia	□ Yes
Sexually active	□ Yes
Age at first intercourse	
Total lifetime partners	
History of STD	□ Yes
Current birth control method	
Age at first period	
Age at menopause	
Do you take HRT	□ Yes
History of endometriosis	□ Yes
History of fibroids	□ Yes
History of infertility	□ Yes
History of recurrent ovarian cysts	□ Yes
History of PCOS	□ Yes
History of painful periods	□ Yes
How long do your periods last	
Do you have regular monthly periods	□ Yes
Are your periods heavy	□ Yes

OBSTETRIC HISTORY

Date of Delivery	Outcome?	# Babies	Birth Weight	Wks at Birth	Sex	Delivery Type	Problems/Complications
	___ Full term ___ Stillborn ___ Premature ___ Miscarriage ___ Termination	___ Singleton ____ Twins ____ 3+			M F	__Vaginal __ C/Section	
	___ Full term ___ Stillborn ___ Premature ___ Miscarriage ___ Termination	___ Singleton ____ Twins ____ 3+			M F	__Vaginal __ C/Section	
	___ Full term ___ Stillborn ___ Premature ___ Miscarriage ___ Termination	___ Singleton ____ Twins ____ 3+			M F	__Vaginal __ C/Section	
	___ Full term ___ Stillborn ___ Premature ___ Miscarriage ___ Termination	___ Singleton ____ Twins ____ 3+			M F	__Vaginal __ C/Section	
	___ Full term ___ Stillborn ___ Premature ___ Miscarriage ___ Termination	___ Singleton ____ Twins ____ 3+			M F	__Vaginal __ C/Section	

FAMILY HISTORY □ **NONE**

Relationship	Health Problem	Onset Age	Age of Death
	☐ Thyroid ☐ Allergies ☐ High Blood Pressure ☐ Diabetes ☐Epilepsy ☐ Stroke ☐ Heart Disease ☐ Mental Illness ☐ Blood Disease ☐ High Cholesterol ☐ Cancer: Type:_____ ☐ Other:		
	☐ Thyroid ☐ Allergies ☐ High Blood Pressure ☐ Diabetes ☐Epilepsy ☐ Stroke ☐ Heart Disease ☐ Mental Illness ☐ Blood Disease ☐ High Cholesterol ☐ Cancer: Type:_____ ☐ Other:		
	☐ Thyroid ☐ Allergies ☐ High Blood Pressure ☐ Diabetes ☐Epilepsy ☐ Stroke ☐ Heart Disease ☐ Mental Illness ☐ Blood Disease ☐ High Cholesterol ☐ Cancer: Type:_____ Other:		
	☐ Thyroid ☐ Allergies ☐ High Blood Pressure ☐ Diabetes ☐Epilepsy ☐ Stroke ☐ Heart Disease ☐ Mental Illness ☐ Blood Disease ☐ High Cholesterol ☐ Cancer: Type:_____ ☐ Other:		

SOCIAL HISTORY

Relationship Status	□ Single □ In a relationship □ Married □ Divorced □ Widowed
Spouse/Partner's Name	
Assigned Gender at Birth	Patient: □ Female □ Male Partner: □ Female □ Male
Are you/have you been a victim of abuse?	□ Sexual □ Physical □ Emotional
Is the abuse on-going?	□ Yes, Please explain:
Tobacco use	□ Never □ Former □ Current # Years: Frequency:
Other forms of nicotine/tobacco	□ Yes □ E-Cigarettes □ Vape □ Patch □ Other
Have you had tobacco cessation counseling	□ Yes
Alcohol use	□ None □ Occasional □ Moderate □ Heavy How many in past week?
How many days in the past year have you consumed 4 or more drinks	
Do you use recreational or illicit drugs	□ Yes How many times in the past year?
Caffeine consumption	□ None □ Occasional □ Moderate □ Heavy
What type of diet are you following	□ Regular □ Vegetarian □ Vegan □ Gluten-free □ Specific □ Carbohydrate □ Cardiac □ Diabetic
Exercise level	□ None □ Occasional □ Moderate □ Heavy
Highest level of education	□ Prefer not to answer □ High school graduate □ Some college □ Trade School □ Associates □ Bachelors □ Masters □ PhD
Are you currently in school	□ Yes
Are you currently employed	□ Yes
What is your occupation	
Do you have an advanced directive	□ Yes
Is a blood transfusion acceptable in an emergency	□ Yes □ No

PAST SURGERIES □ **NONE**

Type: _____ Date: _____ Where: _____

Type: _____ Date: _____ Where: _____

Type: _____ Date: _____ Where: _____

Type: _____ Date: _____ Where: _____

Type: _____ Date: _____ Where: _____

PAST MEDICAL HISTORY **(If no, leave blank)**

		Yes	Comments
Breast			
	Fibrocystic Breasts		
	Other		
Cancer			
	Breast		
	Cervical		
	Colon		
	Endometrial/Uterine		
	Lung		
	Ovarian		
	Skin		
	Vaginal		
	Vulvar		
	Other		
Cardiology			
	Arrythmia		
	Atrial Fib/flutter		
	Coronary Artery Disease		
	Elevated cholesterol		
	Heart attack		
	Heart disease		
	High blood pressure		
	Murmur/Mitral Valve Prolapse		
	Other		
Dermatology			
	Acne		
	Eczema		
	Latex allergy		
	Psoriasis		
	Other		
Endocrine			
	Diabetes		
	Glucose Intolerance/Insulin Resistance		
	Hyperthyroidism		
	Hypothyroidism		
	Osteopenia		
	Osteoporosis		
	Prolactinoma		
	Vitamin Deficiency		
	Other		

		Yes	Comments
ENT			
	Seasonal Allergies		
	Other		
Gastrointestinal			
	Celiac Disease		
	Crohn's/Ulcerative Colitis		
	Gallbladder Disease		
	Hemorrhoids		
	Irritable Bowel Syndrome		
	Reflux/Ulcers		
	Other		
Genetics			
	Cancer Gene		
	Birth Defects or Inherited Disease		
	Cystic Fibrosis Screening Positive		
	Fragile X Screening Positive		
	SMA Screening Positive		
	Other		
Hematology			
	Anemia		
	Bleeding Disorder/Thrombophilia		
	Blood Clotting Disorder/Factor V Leiden		
	Blood Transfusion		
	DVT/Pulmonary Embolism		
	Other		
Infectious Disease			
	Chicken Pox		
	Hepatitis		
	HIV/AIDS		
	MRSA		
	Positive PPD/TB		
	Shingles		
	Other		
Nephrology			
	Kidney Infections		
	Kidney Stones		
	Renal/Kidney Disease		
	Other		
Neurology			
	Aneurism		
	Autism		
	Dementia		
	Headaches/Migraines		
	Multiple Sclerosis		
	Seizures/Epilepsy		
	Stroke/TIA		
	Other		
Ob/Gyn (Cont.)			
	Gestational Diabetes		
	Herpes		
	Pelvic Pain		
	Pelvic Prolapse		
	Polycystic Ovary Syndrome		
	Preeclampsia		
	Premature Ovarian Failure		
	STD		
	Other		

		Yes	Comments
Orthopedic			
	Chronic Back Pain		
	Fractures		
	Other		
Psychiatric			
	ADD/ADHD		
	Anxiety Disorder		
	Bipolar Disease		
	Depression		
	Eating Disorder		
	Mental Illness/Disorder		
	PMS/PMDD		
	PTSD		
	Other		
Pulmonary			
	Asthma		
	Other		
Rheumatology			
	Arthritis		
	Autoimmune Disease		
	Chronic fatigue syndrome		
	Connective Tissue Disorder		
	Fibromyalgia/Chronic Pain		
	Other		
Urology			
	Interstitial cystitis		
	Bladder Problems		
	Hematuria (blood in urine)		
	Urinary Incontinence		
	Urinary Tract Infections		
	Other		

I certify information above is true and correct to the best of my knowledge:

_____

Patient Name

_____ _____

Patient Signature Date