Health History & Review of Systems

Welcome to Mansfield Ob/Gyn. Please take a few minutes to complete this health questionnaire.

Name _____ Date of birth _____ Race _____ Reason for Visit _____

Emergency contact _____ Primary care provider _____

Medical History

Please check if you and, in some cases, your family members (parents, grandparents, siblings) have had any of the following health problems:

	YOU	FAMILY		YOU	FAMILY
1. Asthma	☐	☐	18. Anemia/sickle cell disease	☐	☐
2. Pneumonia/ lung problems	☐	☐	19. Heart trouble/murmur	☐	☐
3. Kidney infections/stones	☐		20. Autoimmune disorder	☐	☐
4. Bladder/urinary tract problems	☐	☐	21. Thyroid disease	☐	☐
5. Liver or gallbladder problems	☐		22. Seizures	☐	☐
6. Sexually transmitted infections	☐		23. Osteoporosis	☐	☐
7. Abnormal pap smear	☐		24. Tuberculosis/ + PPD	☐	☐
8. Breast lump/abnormal mammogram	☐		25. Diabetes	☐	☐
9. Infectious diseases	☐		26. High blood pressure	☐	☐
10. Ulcers/bowel trouble/gastric reflux	☐		27. High cholesterol	☐	☐
11. Blood transfusion	☐		28. Blood clot/stroke	☐	☐
12. Glaucoma	☐		29. Migraine headaches	☐	☐
13. Arthritis	☐	☐	30. Cancer	☐	☐
14. Broken Bones/trauma	☐		31. Birth defects/genetic disease	☐	☐
15. Hepatitis	☐		32. Depression/psychiatric disorders	☐	☐
16. Eating disorder	☐		33. Alcohol/drug abuse	☐	☐
17. Physical or sexual abuse	☐		34. Other _____	☐	☐

Surgery or hospitalization

Reason:	Date:	Reason:	Date:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What medications do you take? (Include over-the-counter & herbal supplements)

_____ _____ _____

_____ _____ _____

Do you have any allergies? ☐ No ☐ Yes Please list: _____

Menstrual History

Do you have menstrual periods? ☐ No ☐ Yes How old were you when your menstrual periods began? _____

If you still have periods, how many days from the start of one period to the start of the next _____ Number of days of bleeding _____

If you no longer have periods, how old were you when your periods stopped? _____

Obstetric History

Have you ever been pregnant? ☐ No ☐ Yes How many times? _____

Full-term births_____ # Premature births_____ # Living children_____ # Miscarriages_____ # Abortions_____ # Ectopic pregnancy_____

Pregnancy complications (diabetes, high blood pressure, hemorrhage, etc): _____

(continued on other side)

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Sexual History

Have you ever been sexually active? ☐ No ☐ Yes Total number of partners: _____ ☐ Male ☐ Female ☐ Both

How many different partners have you had in the past year? _____ How long have you been with your current partner? _____

What is your current form of birth control (if applicable)? _____ Do you use condoms? _____

Are you now in a relationship where you feel threatened? ☐ No ☐ Yes

Lifestyle

Check if you currently use: Tobacco ☐ No ☐ Yes Alcohol ☐ No ☐ Yes Recreational Drugs ☐ No ☐ Yes

Were you ever a smoker in the past? ☐ No ☐ Yes If so, when did you quit? _____

Do you exercise regularly? ☐ No ☐ Yes Type & frequency _____

Is your diet healthy? ☐ No ☐ Yes How many people live at home with you? _____

Are you currently employed? ☐ No ☐ Yes Occupation _____

Date of your last immunization or health screening (if applicable):

Pap smear _____ Colonoscopy/sigmoidoscopy _____ Hepatitis B vaccination _____

Mammogram _____ Tetanus vaccination _____ HPV vaccination _____

Bone density scan _____ Cholesterol test _____ Diabetes screening _____

Review of Systems

Are you **currently** having problems with any of the following?

Constitutional
- ☐ Fever
- ☐ Fatigue or insomnia
- ☐ Night sweats or hot flashes
- ☐ Weight loss or gain

HEENT
- ☐ Vision changes or double vision
- ☐ Ear aches
- ☐ Sinus problems
- ☐ Sore throat
- ☐ Mouth sores

Respiratory
- ☐ Wheezing or coughing
- ☐ Shortness of breath

Cardiovascular
- ☐ Chest pain
- ☐ Heart palpitations

Gastrointestinal
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Frequent diarrhea
- ☐ Nausea/vomiting

Genitourinary
- ☐ Pain with urination
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Urinary urgency
- ☐ Incontinence

Reproductive
- ☐ Heavy or painful periods
- ☐ Irregular bleeding
- ☐ Breast lumps or discharge
- ☐ Pelvic pain or pain with intercourse
- ☐ Vaginal itching or burning
- ☐ Abnormal vaginal discharge

Metabolic/Endocrine
- ☐ Abnormal thirst
- ☐ Cold or heat intolerance
- ☐ Change in hair growth

Neuro/Psychiatric
- ☐ Dizziness or trouble walking
- ☐ Headaches
- ☐ Numbness
- ☐ Depression or anxiety

Skin
- ☐ Rashes or severe itching
- ☐ Growths or moles

Musculoskeletal
- ☐ Joint pain
- ☐ Weakness

Hematologic/Lymphatic
- ☐ Frequent bruising
- ☐ Enlarged lymph nodes

Allergic/Immunologic
- ☐ Hives
- ☐ Frequent sneezing/nasal discharge

Any other questions or concerns about your health today? _____