The Women's Center of Southern New England
A member of Women's Health Connecticut

MR#: ☐☐☐☐☐☐☐
Name of Patient:
Date of Birth:
Place Label Here

HEALTH HISTORY QUESTIONNAIRE

MENSTRUAL HISTORY

How old were you when you started your period:	First Day of last period:		Frequency of periods?
Length of each period?	Describe Bleeding ☐ Heavy	☐ Medium	☐ Light
Are Periods Painful? ☐ Yes ☐ No	Are you bleeding or spotting between periods?	☐ Yes	☐ No
Have you ever been sexually active? ☐ Yes ☐ No	If Yes, Are you currently sexually active? ☐ Yes ☐ No	Are your partner(s)	☐ Male ☐ Female

Method of contraception: ☐ Not Needed ☐ None ☐ Pill ☐ Vasectomy ☐ Condoms ☐ Patch ☐ Rhythm Method ☐ NuvaRing
☐ Depo Provera ☐ Nexplanon ☐ Tubal Ligation ☐ IUD…. Type _____ ☐ Other

For women who STOPPED HAVING PERIODS ☐ N/A

What age did you stop having periods?	Have you taken hormone therapy? ☐ No	☐ Yes ☐ In the past ☐ Currently

Are you experiencing any vaginal bleeding?

Gynecological Problems / History

Have you ever had or do you now have any of the following? ☐ **None**

☐ Pain with Sex	☐ PMS	☐ Infertility	☐ Abnormal Uterine Structure	☐ Chronic Pelvic Pain
☐ Urinary Incontinence	☐ Pelvic Inflammatory Disease		☐ Endometriosis or Adenomyosis	☐ DES Exposure when mother was pregnant with you

☐ Other_____

Sexually Transmitted Infections? ☐ Chlamydia	☐ Genital Herpes	☐ Gonorrhea	☐ Genital Warts	☐ Hepatitis B	☐ Hepatitis C	☐ HIV/AIDs	☐ Syphilis	☐ HPV

Last Pap smear (month/year)	Any abnormal Pap Smears? ☐ No ☐ Yes….Any Treatments? ☐ LEEP ☐ Laser ☐ Freezing ☐ Biopsy

Last mammogram: ☐ ? Normal	Last colonoscopy: ☐ ? Normal	Last bone density exam: ☐ ? Normal
☐ ? Abnormal Explain:	☐ ? Abnormal Explain:	☐ ? Abnormal Explain:

Medical History ☐ None

	MYSELF	FAMILY		MYSELF	FAMILY		MYSELF	FAMILY
Anemia	☐	☐	Mental Illness	☐	☐	Thyroid problems	☐	☐
High Blood Pressure	☐	☐	Diabetes	☐	☐	Kidney Disease / Stones	☐	☐
Breast Cancer	☐	☐	Ovarian Cancer	☐	☐	Colon Cancer	☐	☐
Uterine Cancer	☐	☐	Other Cancer	☐	☐	Migraine Headaches	☐	☐
Clotting Disorder	☐	☐	Lupus	☐	☐	Tuberculosis	☐	☐
Stroke / Heart Disease	☐	☐	Osteoporosis	☐	☐	Irritable Bowel Syndrome	☐	☐

Pregnancy History ☐ None

Date (Full birth date)	**Type of Delivery**	**Sex**	**Birth Weight**	**Complications:** (preterm labor, diabetes, bleeding, high blood pressure, postpartum depression. If preterm labor, were medications used?)
	☐ Vaginal ☐ C/S ☐Miscarriage ☐ Abortion			
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Past Obstetrical/ Gynecological Surgeries ☐ None					
	Year		**Year**		**Year**
☐ D&C		☐ Hysteroscopy		☐ Infertility Surgery	
☐ Tubal Ligation		☐ Laparoscopy		☐ Ovarian Surgery	
☐ Hysterectomy		☐ Myomectomy (Uterine Fibroids)		☐ Cesarean section	
☐ Ovarian Cyst Removal		☐ Vaginal or bladder repair for prolapsed or incontinence			
☐ Other:					

Current Medical Concerns / Activities									
Weight change	☐ Yes	☐ No	Abnormal Hair growth	☐ Yes	☐ No	Nausea / Vomiting	☐ Yes	☐ No
Abnormal Bleeding	☐ Yes	☐ No	Problems with Urination	☐ Yes	☐ No	Bowel Changes	☐ Yes	☐ No
Anxiety / Panic	☐ Yes	☐ No	Depression	☐ Yes	☐ No	Trouble sleeping	☐ Yes	☐ No
Night sweats / hot flashes	☐ Yes	☐ No	Breast pain / discharge	☐ Yes	☐ No	Other:		

Allergies:	Last Tdap:	HPV dates:	Last Influenza:

Tobacco Use: ☐ Never ☐ Current _____ # of Cigarettes per day ☐ Former, Quit at age _____	Any Alcohol Use ☐ No ☐ Yes _____# per week
Do you use street drugs? ☐ No ☐ Yes…….. Type and last used:	Do you have any cultural/religious considerations that need special attention? ☐ No ☐ Yes

Exercise? ☐ No ☐ Yes… Frequency each week: (circle) 1X 2X 3X 4X 5X+ Minutes Per session: 20 mins 30 mins 45 mins 60+ mins

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken