



ASHEVILLE WOMEN'S MEDICAL CENTER

A Comprehensive Health Care Questionnaire

Chart# _____ Date _____

Name _____ Date of Birth _____ Age _____

First Last Middle

Address _____

Street City State Zip

Occupation _____ Place of Employment _____ Marital Status S M W D

Your Phone Numbers (H) _____ (W) _____ Spouse or Support Person _____ Phone _____

Where were you born? _____ Education _____

Family Physician _____ Who were you referred by? _____

Medications and Dose
 (Include over-the-counter, prescription drugs, and herbal remedies)

Menstrual History

Age of onset _____

Frequency _____

Duration of flow in days _____

Pain with menstrual flow(0 1 2 3 4 5) _____

Do you lose work due to menses? Y/N _____

Do you take medication for menses? Y/N _____

Birth Control
 (circle type used)

Birth control pills/patch/ring/depo provera _____

Barrier: condom/ foam gel / diaphragm _____

tubal / male vasectomy / IUD _____

Allergies to Medication:

Pregnancy History

How many times pregnant? _____

How many children? _____

Miscarriages? Y / N _____

Abortions? Y / N _____

Ectopics? Y / N _____

C-Section? Y / N _____

Complications of pregnancy? Y / N _____

If yes, please describe: _____

Do you use tobacco in other forms? Y / N _____

Family and Social History

Living situation _____

Children names and date of birth: _____

Sexually active Y / N _____

Have you / Do you smoke? Y / N _____

Packs per day _____

Describe _____

How much alcohol do you use? units/day _____

Do you drink caffeinated drinks? units/day _____

Do you exercise regularly? Y / N _____

Surgeries and/or Biopsies (Including date, type, hospital and surgeon)

Do you now have or did you ever have:

Abnormal Pap Test	Yes	No	Asthma	Yes	No	Bladder infection	Yes	No
Bleeding disorder	Yes	No	Bloody or tarry stools	Yes	No	Bone or joint problems	Yes	No
Breathing problems	Yes	No	Bloody urine	Yes	No	Blood transfusion	Yes	No
Change in bowel habits	Yes	No	Chest pain/heart trouble	Yes	No	Cancer any site	Yes	No
Colitis	Yes	No	Depression/related illness	Yes	No	Diabetes	Yes	No
DES exposure	Yes	No	Elevated cholesterol	Yes	No	Excessive loss of urine	Yes	No
"Female" cancer	Yes	No	Hepatitis/Jaundice	Yes	No	High blood pressure	Yes	No
Infertility	Yes	No	Kidney disorder	Yes	No	Migraine headaches	Yes	No
Miscarriage/abortion	Yes	No	Mental illness	Yes	No	Pelvic Infection(nonvaginal)	Yes	No
Sexual assault/familyviolence	Yes	No	Shortness of breath	Yes	No	Thyroid problems	Yes	No
Weight control problems	Yes	No	Water retention/edema	Yes	No			

Family History: parents/grandparents/siblings

Birth defects	Yes	No	Breast cancer	Yes	No	Colon Cancer	Yes	No
Diabetes	Yes	No	Heart attack	Yes	No	Heart disease	Yes	No
High blood pressure	Yes	No	Osteoporosis	Yes	No	Ovarian cancer	Yes	No
Stroke	Yes	No						

Health Screening History

Last colonoscopy/sigmoidoscopy normal?	Yes	No	Date _____	Last bone density	normal?	Yes	No	Date _____
Last breast ultrasound normal?	Yes	No	Date _____	Last blood work normal?	Yes	No	Date _____	
Last pap test normal?	Yes	No	Date _____	Last mammogram normal?	Yes	No	Date _____	

Please describe your main problem: _____