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? _____

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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:

_____
_____

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

_____
_____
_____
_____
_____
_____
_____
_____
_____

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:_____
_____
_____
_____
_____

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_____
Do you use tobacco in other forms? Y / N
Describe_____
How much alcohol do you use? units/day ____
Do you drink caffeinated drinks? units/day____
Do you exercise regularly? Y / N

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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:_____

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