MFA-PHYSICIANS FOR WOMEN-NOVA HEALTH HISTORY QUESTIONNAIRE

(Please complete both pages of the health history questionnaire for review with your physician)

NAME_____DOB_____/_____/_____Reason for visit_____

Past Medical History

Place a checkmark next to the conditions you have now or have had in the past.

☐ Abnormal pap	☐ Drug Dependency	☐ Mumps
☐ AIDS/HIV	☐ Emphysema	☐ Pacemaker
☐ Alcoholism	☐ Fibromyalgia	☐ Pneumonia
☐ Anemia	☐ Gallbladder Disease	☐ Polio
☐ Anorexia	☐ Glaucoma	☐ Psoriasis
☐ Appendicitis	☐ Gout	☐ Psychiatric Care
☐ Arthritis	☐ Hay Fever/Allergies	☐ Rheumatic Fever
☐ Asthma	☐ Head Injury	☐ Scarlet Fever
☐ Bleeding Disorder	☐ Heart Disease	☐ Seizures
☐ Blood Transfusion	☐ Hepatitis	☐ Sexually Transmitted Infections
☐ Breast Lump/mass	☐ Hernia	☐ Stroke
☐ Cancer	☐ High Blood Pressure	☐ Suicide Attempt
☐ Cataracts	☐ High Cholesterol	☐ Tonsillitis
☐ Chicken Pox/Shingles	☐ Hormone Therapy	☐ Tuberculosis
☐ Colitis	☐ Kidney Disease	☐ Typhoid Fever
☐ Congenital Disorder	☐ Measles	☐ Ulcer(s)
☐ Depression	☐ Migraine	☐ Vaginal Infection
☐ Diabetes	☐ Mononucleosis	☐ Other Illness
☐ Diverticulosis	☐ Multiple Sclerosis	☐

Age started menses:	# days in cycle:	# of days bleeding:	Last menstrual period:	Contraceptive Method:
# of Pregnancies:	# of Live Births:	# of Miscarriages:	# of Abortions:	

CURRENT ALLERGIES SENSITIVITIES, INTOLERANCES

List anything you are allergic/sensitive to (medications, foods, Chemicals, etc) and how each effects you

ALLERGIC TO…..	EFFECT

CURRENT MEDICATIONS

List all medications you are now taking, including those you buy without a prescription. List name, dose and how often per day that you take it.

PAST HOSPITALIZATIONS/SURGERIES

Please list all the times you have been hospitalized, or had an operation

Year	Hospitalization for……..	Illness/Injuries	Surgeries

Family History

Please fill in health information about your family.

Relationship	Age if living	Age at Death	State of Health or cause of death
Father			
Mother			
Brothers			
Sisters			
Spouse			
Children			

Have any blood relative had any of the Following? If so, indicate relationship to you

SOCIAL PROFILE

Illness	Family Member
Alcoholism	
Arthritis	
Asthma/Emphysema	
Blood Disease	
Cancer	
Colitis	
Diabetes	
Drug Dependency	
Heart Disease	
High Blood Pressure	
Mental Problems	
Migraines	
Stroke	
Suicide	
Tuberculosis	
Other:	

Have you traveled outside the U.S. in the past 2 years? Where? When?

Where were you born?	**Have you ever had a problem with drugs/alcohol?**
Level of education?	**Do you ever use illegal/recreational drugs?**
Current Employment?	**Do you drink alcohol?**
Recent change in Job?	**How many drinks per day?**
Marital status?	**Are you exposed to fumes/solvents?**
Living with (spouse/significant other/roommate/family)	**Sexual orientation?**
How often do you exercise?	**Do you have cats?**
What exercise do you do?	**When was your last**
	Tetanus:
How much coffee/tea do you drink per day?	**Pneumococcus:**
	Rubella:
Have you ever smoked?	**Hepatitis B:**
	Measles:
How many cigarettes per day? For how many years?	**TB test:**
	Influenza:
What year did you quit smoking?	**Mumps:**
	Shingles:
When was your last	
Pap Smear: Result:	**Any history of sexual assault/abuse? Yes/No No explanations needed unless inclined.**
Mammogram: Result:	
Bone Density Scan: Result:	
Colonoscopy: Result:	

Please list any other physicians/providers who are currently treating you: