Sonacare
Women's Health & Ultrasound

Today's Date: _____

PATIENT HEALTH HISTORY QUESTIONNAIRE

A. NAME: _____ **AGE:** _____**DOB**_____

Marital Status: ☐ Single ☐ Married ☐ Long-term relationship ☐ Divorced ☐ Widowed

Height _____ Weight_____

Reason for this visit_____

Occupation_____

B. MENSTRUAL HISTORY (complete even if post-menopausal or no longer having periods)

1. Age of first period: _____ years. Age of menopause_____years
2. If your Menstrual periods are regular; periods start every: _____ days.
3. If your Menstrual periods are irregular; periods start every: _____ to _____ days. (e.g.12 - 60)
4. Duration of bleeding: _____ days. Is your bleeding heavy(pass large clots/flooding)? ☐Yes ☐No
5. Any bleeding or spotting occur between periods? ☐ Yes ☐ No Bleeding after intercourse? ☐Yes ☐No
6. First day of last Menstrual period: _____
7. Is pain associated with periods? ☐ Yes ☐ No ☐ Occasionally
8. If yes, is it: ☐ before menses ☐ during menses ☐ both
9. Where is your pain located?_____
10. Do you have pain during vaginal intercourse? ☐ Yes ☐ No ☐ Occasionally
11. Do you have pain during urination? ☐ Yes ☐ No ☐ Occasionally

C. PREGNANCY HISTORY (ALL PREGNANCIES) OR ☐ HAVE NEVER BEEN PREGNANT

OBSTETRIC HISTORY INCLUDING TERMINATIONS & ECTOPIC (TUBAL) PREGNANCIES

Year	Place of Delivery or Termination	Duration Pregnancy	Hours of Labor	Type of Delivery	Note Complications Mother and/or Infant • Preeclampsia • Gestational Diabetes • Premature Labor • Other / Specify

D. BIRTH CONTROL HISTORY

1. What birth control method(s) do you currently use?_____
2. For how long?_____
3. What birth control methods have you used in the past?_____

E. SEXUAL HISTORY

1. Do you have a sexual partner? Yes ☐ No ☐ Male ☐ Female ☐
2. Are there concerns about your sexual activity which you may want to discuss with your doctor?

☐ Yes ☐ No

F. PAST OBSTETRICAL/GYNECOLOGICAL SURGERIES: Check any that apply or ☐ None

Surgery	Year	Surgery	Year
☐ D&C	_____	☐ Ovarian Surgery	_____
☐ Hysteroscopy	_____	☐ L cyst(s) removed ovarian	_____
☐ Infertility Surgery	_____	☐ R cyst(s) removed ovarian	_____
☐ Tuboplasty	_____	☐ L ovary removed	_____
☐ Tubal Ligation	_____	☐ R ovary removed	_____
☐ Laparoscopy	_____	☐ Vaginal or bladder repair for prolapsed or incontinence	_____
☐ Hysterectomy (vaginal)	_____	☐ Cesarean section	_____
☐ Hysterectomy (abdominal)	_____	☐ Other (specify)_____	_____
☐ Myomectomy	_____	_____	_____

G. PAST SURGICAL HISTORY (NOT OB/GYN): List all surgeries and their year or ☐ None

Surgery	Mo/Year	Complications

H. PAP SMEAR/MAMMOGRAM HISTORY

1. Date of last pap smear:_____: ☐ Normal ☐ Abnormal
2. Have you had abnormal pap smears? ☐ No ☐ Yes
3. Have you had treatment for abnormal smear? ☐ No ☐ Yes
4. If yes, what type(s) of treatment have you had?

Treatment	Year	Treatment	Year
☐ Cryotherapy	_____	☐ Cone Biopsy	_____
☐ Laser	_____	☐ Loop excision (LEEP)	_____

5. Date of last mammogram:_____

6. Have you had an abnormal mammogram? ☐ No ☐ Yes

OTHER PAST GYNECOLOGICAL HISTORY: Check any that apply or ☐ None

☐ Venereal warts ☐ Herpes-genital ☐ Syphilis ☐ Pelvic Inflammatory Dis.
☐ Endometriosis ☐ Chlamydia ☐ Gonorrhea ☐ Vaginal Infections
☐ HPV ☐ Other (specify) _____

If you have a history of endometriosis:

1. What year was this diagnosed?_____
2. Please list any meds you've tried for management of endometriosis/pelvic pain

_____

3. Do you have a family history of endometriosis? ☐ No ☐ Yes

I. PAST MEDICAL HISTORY: Check any that apply or ☐ None

☐ Arthritis
☐ Diabetes:
  ☐ Diet controlled
  ☐ Pill controlled
  ☐ Insulin controlled
  ☐ Gestational
☐ High Blood Pressure
☐ Breast Cancer
☐ Kidney Disease
☐ Gallstones
☐ Liver Disease, includes hepatitis
☐ Epilepsy
☐ Eating Disorder
☐ Heart Disease
☐ Blood Clots Leg/Thigh
☐ Asthma
☐ Cancer (specify)
_____
☐ Emphysema
☐ Bronchitis
☐ HIV+
☐ Blood Transfusions
☐ Thyroid Disease
☐ Other (specify)
_____
_____
_____

J. CURRENT MEDICATIONS (include dose/amount per day)

Medication	Dose	Frequency

K. DO YOU CURRENTLY?

Smoke cigarettes: ☐ Never ☐ Yes, Packs/Day:_____

☐ Former Years Smoked:_____

Alcohol: ☐ Never ☐ Former ☐ Yes, Drinks/Week:_____ Type:_____

Lifestyle: Are you on a specific diet? ☐ Yes ☐ No If yes, which type of diet: _____

Do you exercise regularly? ☐ Yes ☐ No If yes, what type of exercise_____

Days/Week:_____ Hours/Day: _____

L. DRUG ALLERGIES ☐ YES ☐ NO , LIST:

_____

_____

M. FAMILY HISTORY or ☐ None

	Yes	Deceased *(Note age & cause)*	Affected Relatives *(Father, Mother, Brother, Sister, Son, Daughter)*
Diabetes	☐	_____	_____
Ovarian Cancer	☐	_____	_____
Heart Disease	☐	_____	_____
Endometrial Cancer	☐	_____	_____
Breast Cancer	☐	_____	_____
Colon Cancer	☐	_____	_____
Other/Specify	☐	_____	_____

N. OTHER SYMPTOMS or PROBLEMS: Check any that apply or ☐ None

☐ Weight Loss	☐ Hair Growth	☐ Change in Energy
☐ Weight Gain	☐ Hair Loss	☐ Change in Exercise Tolerance
☐ Breast Discharge	☐ Hot Flushes/Flashing	☐ Change in Urinary Function
☐ High Cholesterol	☐ Physical Abuse/Domestic Violence	☐ Other (specify)_____

PATIENT SIGNATURE DATE