WWC OB-GYN
Wellesley Women's Care

Wellesley Women's Care, P.C.
Health Questionnaire for our New Patients

Name:	**DOB:**
Address:	**Cell:**
	Home:
	Business:
Occupation:	**Religion(optional)**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Spouse / Partners Name:	**Previous or referring doctor:**

PERSONAL HEALTH HISTORY		
HOW TALL ARE YOU?	WHAT IS YOUR USUAL WEIGHT ?	WHAT IS YOUR CURRENT WEIGHT?

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio ☐Tuberculosis

Surgeries

Year	Reason	Hospital

Other hospitalizations, injuries, broken bones, auto accident etc

Year	Description	Hospital/City

Have you ever had an anesthesia complication ?	☐ Yes	☐ No
Have you ever had a blood transfusion?	☐ Yes	☐ No
Do you know your Blood Type ?	☐ Yes	☐ No
Have you ever received RhoGAM?	☐ Yes	☐ No

		Recent changes in:
☐ Cancer	☐ Migraine Headaches / Frequent headaches	
☐ Frequent nose bleeds / Sinusitis	☐ Heart disease	☐ Weight
☐ Asthma / Hay fever	☐ Heart murmur Mitral Valve Prolapse	☐ Energy level
☐ Respiratory Disease	☐ High Blood pressure	☐ Ability to sleep
☐ Pneumonia	☐ Chest pain with exertion	
☐ Frequent cough / Shortness of breath	☐ Anemia / Blood Disorders	
☐ Epilepsy / Neurological Disorder	☐ Hemorrhoids	
☐ Contact lenses / Visual Changes	☐ Varicose Veins / Phlebitis	

Patients initials:________

Gall Bladder disease	☐ Blood, Sugar or Protein in urine	
☐ Blood in bowel movements	☐ Goiter / Thyroid	
☐ Abdominal pain after meals	☐ Loss of urine when coughing / sneezing	
☐ Any changes in bowel habits	☐ Kidney Stones	
☐ Diabetes	☐ Painful urination	
☐ Kidney Disease	☐ Hepatitis, Jaundice, Mononucleosis	☐ Depression / Anxiety

Allergies to Any Medication

Name of Medication	**Reaction**

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?			☐ Yes	☐ No	
	If yes, are you on a physician prescribed medical diet?			☐ Yes	☐ No	
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?			☐ Yes	☐ No	
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?			☐ Yes	☐ No	
Tobacco	Do you use tobacco?			☐ Yes	☐ No	
	☐ Cigarettes – pks./day	☐ # of years	☐ Or year quit			
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No	
	Have you ever given yourself street drugs with a needle?			☐ Yes	☐ No	

Patients initials:________

Sex	Are you sexually active?	☐	Yes	☐	No
	Have ever had a sexually transmitted disease?	☐	Yes	☐	No
	If not trying for a pregnancy list contraceptive or barrier method used:				
	Do you have any history of Herpes exposure?	☐	Yes	☐	No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. **Would you like to speak with your provider about your risk of this illness?**	☐	Yes	☐	No
Personal / Preventative Health safety	Do you live alone?	☐	Yes	☐	No
	Do you have frequent falls?	☐	Yes	☐	No
	Do you have vision or hearing loss?	☐	Yes	☐	No
	Do you wear seatbelts ?	☐	Yes	☐	No
	Do you do self breast exams ?	☐	Yes	☐	No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. **Would you like to discuss this issue with your provider?**	☐	Yes	☐	No

GYNECOLOGICAL HISTORY

Date of last menstruation: Age at onset of menstruation:				
Period every _____ days (28-30) How many days do you normally flow ? ______ (3-5, 5-7)				
Is your flow Light Average Heavy				
Do you experience irregularity, spotting, pain, or discharge?	☐	Yes	☐	No
Do you experience any clots, cramping?	☐	Yes	☐	No
Are you having any sexual problems or concerns ?	☐	Yes	☐	No
Any discomfort with intercourse?	☐	Yes	☐	No
Are you pregnant or breastfeeding?	☐	Yes	☐	No
Are you trying to conceive?	☐	Yes	☐	No
Did you ever have any trouble conceiving a pregnancy?	☐	Yes	☐	No
Did your mother take Diethylstillbestrol (DES) While pregnant with you ?	☐	Yes	☐	No
Any urinary tract, bladder, or kidney infections within the last year?	☐	Yes	☐	No
Do you have excessive vaginal discharge ?	☐	Yes	☐	No
Are you having vaginal itching or irritation?	☐	Yes	☐	No
Any blood in your urine?	☐	Yes	☐	No
Any problems with control of urination?	☐	Yes	☐	No
Any hot flashes or sweating at night?	☐	Yes	☐	No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐	Yes	☐	No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐	Yes	☐	No
Have you ever had an abnormal Pap smear? If yes, When ?	☐	Yes	☐	No
Date of last Pap smear?				
Date of last mammogram ? Other Breast Imaging ?				

Patients initials:________

OBSTETRICAL HISTORY

Please list the number of times:	
Pregnant	
Live Children	
Premature Births	
Miscarriages	
Abortions	

Year	Outcome*	Weeks Pregnant	Hours in labor	Type of Anesthesia	Total Weight Gain	Male or Female	Fetal Wt.	Breast/ Bottle	Complications/ Fetal Condition	Place of delivery

*Outcome NVD- Normal Vaginal Delivery , CS- Cesarean Section, Misc-Miscarriage, FD- Fetal loss Ab-Abortion

Is your Husband or Partner in Good Health ?	Yes No

	AGE	**Significant Health Problems**
Father		
Mother		
Grandmother Maternal		
Grandfather Maternal		
Grandmother Paternal		
Grandfather Paternal		
Sibling		
M/F		
M/F		
M/F		
M/F		
M/F		

Significant Health Problems
Birth defects, high blood pressure, Cancer, Diabetes, Thyroid disease, Epilepsy, mental illness, twins, blood disease, stroke, heart attack, hysterectomy, kidney disease

Is there anything else about your medical, surgical or family history that you feel we should know ?

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Patients initials:________