

Midwifery Health History Questionnaire

Patient's Name _____ Name you would like to be called _____ Today's Date _____

Date of Birth _____ Race _____ Partner's Name _____

Allergies(medications, latex, food, iodine, etc.) _____

Describe reaction: _____

Medication use:

List all medications, including over the counter drugs like aspirin or laxatives; also list vitamins, diet supplements, herbal preparations, and homeopathic or natural remedies:

Name	Dosage	How often	When did you begin	Purpose

Gynecological History:

What was the first day of your last menstrual period? _____

Age at first period _____ Age of first intercourse _____ Number of lifetime partners: 1 2-4 >4

Are your periods regular? yes no lasting ____-____ days

Have you ever had a sexually transmitted disease (herpes, chlamydia, gonorrhea, wart virus or HIV)?

Explain: _____

When was your last Pap _____ What was the result? _____ Have you ever had a colposcopy? yes no

Have you ever had a LEEP, cone biopsy, or any other cervical surgery?

Explain: _____

Have you experienced infertility or did you use artificial reproductive technology to conceive? _____

Have you had any gynecological disorders or surgeries? _____

What have you used for contraception most recently? _____

Have you had a history of breast masses, biopsies, breast surgeries? _____

Past Medical History: Have you ever had (if yes, please provide details on space provided):

- | | |
|---|--|
| <input type="checkbox"/> severe or frequent headaches _____ | <input type="checkbox"/> depression, eating disorder or other mental health problems _____ |
| <input type="checkbox"/> visual or hearing problems _____ | <input type="checkbox"/> chickenpox _____ |
| <input type="checkbox"/> high cholesterol _____ | <input type="checkbox"/> excessive bleeding, bruising or blood transfusions _____ |
| <input type="checkbox"/> thyroid problems _____ | _____ |
| <input type="checkbox"/> liver problems (hepatitis, jaundice) _____ | <input type="checkbox"/> breast cancer or other breast problems _____ |
| <input type="checkbox"/> diabetes _____ | <input type="checkbox"/> bladder or kidney problems (infections or stones) _____ |
| <input type="checkbox"/> lung problems (asthma, TB) _____ | <input type="checkbox"/> seizures or neurological problems _____ |
| <input type="checkbox"/> high blood pressure _____ | <input type="checkbox"/> uterine, ovarian or cervical cancer _____ |
| <input type="checkbox"/> muscle, joint or bone problems _____ | <input type="checkbox"/> problem receiving anesthetics _____ |
| <input type="checkbox"/> strokes or clots _____ | <input type="checkbox"/> other types of cancer _____ |
| <input type="checkbox"/> skin problems _____ | <input type="checkbox"/> infertility _____ |
| <input type="checkbox"/> heart problems _____ | <input type="checkbox"/> rape or sexual abuse _____ |
| <input type="checkbox"/> stomach or intestinal problems (ulcers, rectal bleeding) _____ | <input type="checkbox"/> other health concerns _____ |
| _____ | _____ |

Surgical history: Have you ever had (please indicate year in space provided):

- | | |
|--|---|
| <input type="checkbox"/> tonsillectomy _____ | <input type="checkbox"/> gall bladder removal _____ |
| <input type="checkbox"/> surgery to cervix _____ | <input type="checkbox"/> breast surgery _____ |
| <input type="checkbox"/> dental surgery _____ | <input type="checkbox"/> cesarean birth _____ |
| <input type="checkbox"/> hysterectomy _____ | <input type="checkbox"/> tubal ligation _____ |
| <input type="checkbox"/> appendectomy _____ | <input type="checkbox"/> laparoscopy _____ |
| <input type="checkbox"/> bladder surgery _____ | <input type="checkbox"/> other surgeries _____ |

