Dr, Elaine Huber
Women'sCare
903 US Highway 202 Suite 2A
Raritan, New Jersey 08869
908-231-6836/Fax 908-231-6862

We request you complete the following questionnaire so that we can more effectively asses your needs. We realize that this health history is quite lengthy but its comprehensive nature will provide us with a fairly complete summary of your relevant medical history. If you have difficulty understanding or answering any of these questions, we will be happy to assist you with the problem areas at the time of your visit.

Please Complete All Items Date:_____

Name_____Birth Date_____Age____

Married Single Divorced Separated Widowed Domestic Partner Civil Union

Reason for your visit today_____

My Last Pelvic Exam was (Date)_____( ) Never

My Last Pap Test was (Date and result)_____( ) Never

Any Abnormal Pap_____ History of HPV_____ Vaccination for HPV_____

History of Dysplasia_____ If yes, Cone Biopsy____Leep_____Cryo____Laser____Colposcopy____

Do you perform breast exams regularly?_____

My Last Mammogram was (Date and Result)_____( ) Never

My Last Bone Density was (Date)_____( ) Never

My Last Colonoscopy was (Date)_____( ) Never

I GYNECOLOGICAL HISTORY

Last Menstrual period began (Date)_____Normal?_____ Days Lasted_____

My Flow Is (Circle One) Scant Moderate Heavy Any painful periods?_____

Bleeding Between Periods?_____Changes in Cycle_____

Any Menstrual Abnormalities Concern_____

Do You Have Abnormal Vaginal Discharge_____ Irritation_____ Itching_____ Odor_____

Do You Have Burning and/or Pain when You Pass Urine_____Have you uncontrolled loss of urine_____

Are You Currently Attempting To Get Pregnant_____

Have You Had or Having a Difficult Time Getting Pregnant_____

Are You Having or Had Hot Flashes_____Do You Have Concerns About Menopause_____

II Habits

I Smoke_____Pack(s) Per Day and I Have For _____Years

I Used To Smoke _____Pack(s) Per Day and Quit _____Months/Years Ago

I Have _____Drinks/Beer a Day/Week (Circle) I Have Concerns With My Drinking Habits Y N

Any Over The Counter Medicines/Street Drugs I Take Are (Please List and Include Sleep Aids, Diet Pills, Aspirin, Tranquilizer, etc.)_____

I Am A Recovering Alcoholic Y N I Am A Recovering Drug User Y N

III Diet History

I Have Had Problems with Excessive Weight Gain or Loss Yes____ No_____

I Have Had Problems with Controlling Food Intake (Binging/Purging/Anorexia/Bulimia) Yes No

IV Exercise History/Habits

Do You Exercise Regularly Yes_____ No _____

Please Describe Type of Exercise _____Frequency_____

V Birth Control

Put an "X" After the Method or Methods You Have Used "*" If You Are Currently Using

Method	Now	Past	Length Used	Any Problems
Pills				
IUD				

Condoms (Rubbers) _____

Diaphragm & Jelly _____

Rhythm/Natural _____

Method _____ **Now** **Past** **Length Used** **Any Problems** _____

Withdrawal _____

Spermicides _____

Cervical Cap _____

Depo-Provera _____

Norplant _____

Sterilization (Tubal) _____

Sterilization (Vasectomy) _____

Other _____

VI. Sexual History

Sexual Orientation (circle one) Heterosexual Homosexual Bisexual

Of Sex Partners_____I Have/Have Had Herpes____and/or Chlamydia_and/or Genital Warts_____

Other Sexually Transmitted Disease (STD)_____ I Have/Have Had Pelvic Inflammatory PID_____

Any Pain During: Intercourse____ Menstrual Cycle____ Urination____

Have You Had Bleeding During or After Sex_____

Often Questions About Sex and/or Relationships Are Hard To Ask, But We Are Here To Help Answer Any Questions You May Have.

Do You Wish To Discuss Any Of These Now? Yes____ No _____ Not Sure_____

Have You Ever Been Hit, Slapped, Kicked or Otherwise Physcially Been Hurt By Someone Yes No

Have You Ever Been Forced To Have Sex When You Did NOT Want To Yes No

VII. Obstetric History

Total # Of Pregnancies____# Of Miscarriages If Any ____# Of Terminations Of Pregnancy____

Of Living Children _____

My Past Pregnancy History Is: (Please include live births and still births)

Born: Month/Year	Place	Weight	Sex	Type of Delivery "V" Vaginal "C" C-Section	Complications
1					
2					
3					
4					
5					
6					

VIII. Personal Health History

I Have/Have Had (please check)		I Have/Had Vaccination for (please date)
( ) Chicken Pox	( ) Kidney Disease	( ) MMR
( ) Cancer	( ) Urinary Tract Infection (UTI)	( ) Hepatitis B
( ) Blood Transfusion	( ) Depression	( ) Tetanus
( ) Anemia	( ) Thyroid Problems	( ) Influenza Vaccine
( ) Severe Headaches	( ) Breast Lump (s)	( ) Pneumococcal Vaccine
( ) Epilepsy	( ) Nipple Discharge	( ) Hair Loss
( ) High Blood Pressure	( ) Bowel Disorder	( ) Hair Increase
( ) Heart Disease	( ) Stomach Ulcers or Hiatal Hernia	( ) Skin Problems
( ) Rheumatic Fever	( ) Asthma/Respiratory Disease	( ) Gallbladder Disease
( ) Arthritis	( ) Varicose Vein/Thrombophlebitis	( ) Liver Disease
( ) Diabetes	( ) Hyperlipidemia High Cholesterol	

Any Other Serious Medical Illness:_____

_____

Any Hospitalization's/Operations (List Conditions/Operation and Date_____

_____

Allergies (Please List Drug and/or Substance Allergies) ( ) None Latex Allergies Yes No

Current Vitamins/Herbs/Supplements_____

_____

Current Medications (List Doses and Frequency Prescribed or Over The Counter)_____

_____

_____

_____

IX. Family History

I Have Parents, Grandparents, Brothers and/or Sister With: (Check The Disease and List The Relative With The Problem)

( ) Heart Attack_____ ( ) Stroke_____

( ) High Blood Pressure _____ ( ) Hyperlipidemia/high cholesterol_____

( ) Diabetes _____ ( ) Cancer (include type)_____

( ) Osteoporosis_____ ( ) Inherited Disorders_____

( ) Thyroid Disease_____ ( ) Multiple Gestation (Twins Triplets)_____

( ) Alzheimer's_____ ( ) Obesity_____

( ) Mental Illness_____ ( ) Other_____

X. Peri Menopausal/Menopausal

Symptoms	Often	Occasional	Never
Night Sweats			
Hot Flashes			
Sleep Disturbances			
Vaginal Dryness			
Urinary Leakage			
Inability to Concentrate			
Memory Loss			
Moodiness			
Anxiety			
Depression			
Decrease in Libido			
Decrease in Energy/Lethargy			