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HEALTH AND HISTORY QUESTIONNAIRE

Name: _____
DOB: _____

Date: _____

Medical History (Have you ever had any of the following?):

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Blood Clots in Lungs/Legs | <input type="checkbox"/> Epilepsy/Seizure Disorder | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Heart Disease/Attack | <input type="checkbox"/> Gallbladder Disease | <input type="checkbox"/> Migraines | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Liver Disease/Hepatitis | <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Chicken Pox |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Kidney Infections/Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Genetic Condition |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Bladder Infections/Disease | <input type="checkbox"/> Asthma | <input type="checkbox"/> Blood Transfusion |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Pelvic Infections/Masses | <input type="checkbox"/> Drug/Alcohol Problems | <input type="checkbox"/> Cancer (specify) |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Thyroid Disorder | _____ |
| <input type="checkbox"/> Seasonal Allergies | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Pneumonia | _____ |

List all allergies to medications: _____

Check box if there are NO known allergies

List all medications you are currently taking, including over the counter medications, vitamins, and herbal remedies:

<u>Medication</u>	<u>Strength</u>	<u>Frequency</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all surgeries, procedures you have had, including oral surgery:

<u>Date</u>	<u>Surgery/Procedure</u>
_____	_____
_____	_____
_____	_____

List all hospitalizations:

<u>Date</u>	<u>Reason for Hospitalization</u>
_____	_____
_____	_____
_____	_____

Family History (Please list all relatives with a history of the following):

- | | | |
|---|--|--|
| <input type="checkbox"/> Heart Disease/Attack | <input type="checkbox"/> Gallbladder Disease | <input type="checkbox"/> Genetic Condition |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Liver Disease/Hepatitis | <input type="checkbox"/> Cancer (specify) |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Kidney Disease | _____ |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Bladder Disease | <input type="checkbox"/> Other (specify) |
| <input type="checkbox"/> Emboli/Blood clots | <input type="checkbox"/> Thyroid Disorder | _____ |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Autoimmune Diseases | _____ |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Breast Cancer | _____ |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Colon Cancer | _____ |
| <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Ovarian Cancer | _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Uterine Cancer | _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Substance abuse | _____ |

Gynecological/Obstetrical History:

Age of first menses/period: _____ Age of menopause: _____ Last menstrual cycle: ___/___/___
 Cycles occur every ___ days, lasting ___ days Pain with menses? Y/N Heavy flow? Y/N
 Ovarian cysts: Y/N Uterine fibroids? Y/N

Sexual reference: ___ Heterosexual Sexually active: ___ Yes
 ___ Homosexual ___ No
 ___ Bisexual ___ Virginal

Method of Birth Control:

Have you ever had any of the following sexually transmitted infections?

- | | |
|--|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Chlamydia |
| <input type="checkbox"/> Condom | <input type="checkbox"/> Gonorrhea |
| <input type="checkbox"/> Oral/ Pill, Brand: | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> OrthoEvra Patch | <input type="checkbox"/> Hepatitis C |
| <input type="checkbox"/> Vaginal Ring | <input type="checkbox"/> Herpes simplex (HSV) |
| <input type="checkbox"/> Tubal ligation/Essure | <input type="checkbox"/> HIV |
| <input type="checkbox"/> IUD | <input type="checkbox"/> HPV (Human Papilloma Virus) |
| <input type="checkbox"/> Depo-Provera Injection | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Partner had vasectomy | <input type="checkbox"/> Trichomonas |
| <input type="checkbox"/> Natural family planning | <input type="checkbox"/> Never had any |

Date of last pap smear: ___/___/___
 Have you ever had an abnormal pap? Y/N If you did, did you have a LEEP/conization procedure? Y/N

Date of last mammogram: ___/___/___ ___ Normal ___ Abnormal ___ Never had one
 Date of last bone density: ___/___/___ ___ Normal ___ Abnormal ___ Never had one

Obstetrical History (Please list all pregnancies including miscarriages, stillbirths, ectopics, and abortions):

<u>Year</u>	<u>M/F</u>	<u>Weight</u>	<u>Vaginal/Csection</u>	<u>Months @ Birth</u>	<u>Problems/Complications</u>	<u>Child's Name</u>

Social History:

Alcohol Use: Y/N If YES, ___ drinks per day/week Exercise: Y/N Type and frequency _____
 Tobacco Use: Y/N If YES, ___ packs per day for ___ years Caffeine: Y/N If YES, ___ caffeinated drinks per day/week
 Street Drug Use: Y/N Type and frequency _____
 Sexual Abuse: Y/N If YES, are you safe now? Y/N Counseling? Y/N
 Physical Abuse: Y/N If YES, are you safe now? Y/N Counseling? Y/N
 Emotional Abuse: Y/N If YES, are you safe now? Y/N Counseling? Y/N

Review of Systems (Do you currently have any of the following?):

- | | | |
|--|---|---|
| <input type="checkbox"/> Generally healthy | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Urgency |
| <input type="checkbox"/> Recent Weight gain or loss of 20lbs | <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Stomach bloating/pain |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Vaginal discharge |
| <input type="checkbox"/> Vision changes | <input type="checkbox"/> Constipation | <input type="checkbox"/> Irregular bleeding |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Pelvic pain |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Heartburn/Reflux | <input type="checkbox"/> Pain/bleeding with intercourse |
| <input type="checkbox"/> Joint/Muscle pain | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Breast lumps |
| <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Burning with urination | <input type="checkbox"/> Back pain |

Signature: _____

Today's Date: _____