Health Questionnaire

Monarch Healthcare
Delivering tomorrows promises, today.

Name _____ Date of Birth _____ Age _____ Date _____

Family Practice Physician _____ Preferred Pharmacy _____

Problems to Discuss During Your Visit:

1. _____
2. _____
3. _____
4. _____

Do You Have any Allergies?: *List all allergies including medication, food, skin, environment, etc.*

_____
_____

Current Medications: *List all medications including: Medication, Dosage, Prescriber and Reason for medication.*

_____
_____
_____
_____

Surgery History:

Date	Type of Surgery	Date	Type of Surgery

Pregnancy History: *Include all miscarriages, abortions or tubal pregnancies.*

Date of Delivery	# Weeks at Delivery	Hours in Labor	Birth Weight	Sex	Delivery Type – Vaginal, CSection, Forceps	Complications

Medical History: *List current problems, past diagnoses and hospitalizations.*

1.	4.	7.
2.	5.	8.
3.	6.	9.

Examples: Diabetes, Depression, Stroke, Anemia, STDs, High Blood Pressure, Asthma, etc.

Do You Smoke? Yes No How many cigarettes a day? _____
Do You Drink? Yes No How much? _____

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Reproductive History:

Age of 1st Menses _____
Date of Last Period _____
Date of Last Pap Smear _____
Date of Last Mammogram _____
Date of Last Colonoscopy _____
Date of Last Bone Density Scan _____

Have you ever had an abnormal pap smear? Y N

Sexual History:

Are you using any method to prevent pregnancy: Yes No
If Yes which type (please circle)? Pill Tubal Vasectomy Condoms Depo-Provera IUD Diaphragm Rhythm Other _____
Do you have pain with intercourse? Yes No

Family Medical History:

	Yes	No	Relative (Maternal/Paternal		Yes	No	Relative (Maternal/Paternal)
Breast Cancer				Heart Disease			
Colon Cancer				High Blood Pressure			
Ovarian Cancer				Kidney Disease			
Endometrial Cancer				Blood Clotting Disorders			
Diabetes							
Other_____				Other_____			
Other_____				Other_____			