CBWC HEALTH QUESTIONAIRE

Sexually Active? Yes No

Are you currently pregnant? Yes No

What is the history of your present illness? For example: When did your symptoms start and what symptoms are you experiencing? Please give as much detail as you are able: _______________________

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Please circle all past medical conditions:

Abnormal pap smear	Asthma	Anemia
Anxiety	Autoimmune Disorder	Blood Transfusion
Breast Cancer	Breast Disease	Cerebral Palsy
Cervical Cancer	Stroke	Colon Cancer
Coronary Artery Disease	Chronic Renal Failure	Dementia/Alzheimer's
Depression	Diabetes-Gestational	Diabetes-Type 1
Diabetes-Type 2	Diverticulitis/Diverticulosis	DVT / Blood Clot
Endometrial Hyperplasia	Endometriosis	Gastritis
GI Bleed	GERD	Hearing Loss/Deafness
Hyperlipidemia	Hypertension	Hypothyroidism
Hepatitis B	Hepatitis C	Incontinence/Urinary
Infertility	Kidney Disease	Kidney Stone
Liver Disease	Neurologic Disorder	Obesity
Osteoarthritis	Osteopenia	Osteoporosis
Polycystic Ovarian Syndrome	Rheumatoid Arthritis	RH Sensitized
Seizure Disorder	Sleep Apnea	Uterine Anomaly
UTI-Recurrent	Valvular Heart Disease	Vitamin D Deficiency

Please circle all past surgeries:

Abdominoplasty	Appendectomy	Back Surgery
Bilateral Tubal Ligation	Breast Augmentation	Breast Lumpectomy
Breast Mastectomy	Breast Reduction	Bilat Salpingo-Oophorectomy
Coronary Artery Bypass Graft	Carotid Endarterectomy	Carpal Tunnel
Cataract Extraction	Cervical Care	Cholecystectomy
Colon Resection	C-Section	D & C
Endometrial Ablation	Essure	Gastric Bypass
Hemorrhoidectomy	Hernia Repair	Hip Replacement
Hysterectomy	Knee Arthroscopy	Knee Replacement
Laparoscopy	LEEP	Laparoscopic Vag Hysterectomy
Mitral Valve Replacement	Left Ovary Removed	Right Ovary Removed
Pacemaker	Parathyroidectomy	Rotator Cuff Repair
Suburethral Sling	Total Abd Hysterectomy	Total Abd Hysterectomy w/BSO
Total Lap Hysterectomy	Total Lap Hysterectomy w/BSO	Thyroidectomy
Total Vag Hysterectomy	Total Vag Hysterectomy w/BSO	Tonsillectomy
Urinary Incontinence Surgery		

Anesthesia Problem? Yes No ______________________________

Surgical Complications? Yes No ______________________________

Post-Op Delirium? Yes No ______________________________

Still Having Menses? Yes No ______________________________

Last Menstrual Period? ______________________________

Menstrual Interval?

14 days 21 days 28 days 30 days Greater than 30 days

Menstrual Duration? (Days) 1 2 3 4 5 6 7 8 9

10 11 12 13 14

Menstrual Flow? Light Medium Heavy Excessive

Tampon Or Pad Use? Use pads only Tampons only Both

How often do you change your tampon or pad? (Circle) Less than every 1 hour

Every 1 hour Every 2 hours Every 3 hours Every 4 hours Every 5 hours Every 6 hours

More than 6 hours ____

Date of Last Pap Smear ____

Pap Smear Results ____

If you had a Colonoscopy, what was the date? ____

If you did have a Colonoscopy, what were the results? _____________________________________

Date of Last Mammogram? ____

If you had a Mammogram, what were the results? _____________________________________

Date of your last DEXA? ____

If you had a DEXA, what were the results? ____

History of abnormal paps? Yes No

History of STD? Yes No

STD (Circle)

Chlamydia Gonorrhea Syphilis

Trichomonas Herpes HPV

HIV Hepatitis B Hepatitis C

Partners? None Male Female

Number of partners in the past? ______________

Number of partners in the present? ______________

What type of contraception do you use? ____

Comments ____

Have you received the Gardasil Vaccine? Yes No

Have you completed the Gardasil Series? Yes No

Comments regarding Gardasil ____

Domestic Abuse? Yes No

Comments ____

Family History (Circle all that apply)

Alcoholism	Arthritis	Asthma
Bleeding Disorder	Blood Clots	Breast Cancer
Cervical Cancer	CHD/Coronary Heart Disease	CHD Male under 55
CHD Female under 55	Colon Cancer	Colon Polyps
Depression	Diabetes	Endometriosis
Headaches	Heart Disease	Hypertension
Hyperlipidemia	Kidney Disease	Lung Cancer
Other Cancer	Osteoporosis	Ovarian Cancer
MS	Psychiatric Care	Respiratory Disease
Seizures	Stroke	Suicide
Thyroid Disease	Uterine Cancer	Weight Disorder

Check if:

No Family History of Breast Cancer ________________

No Family History of Ovarian Cancer ________________

No Family History of Colon Cancer ________________

No Family History of Diabetes ________________

No Family History of Hypertension ________________

No Family History of Diabetes Mellitus ________________

Social History: Circle all that apply

Single	Married	Alternative Lifestyle
Divorced	Separated	Engaged
Widowed	Stable Relationship	Stressful Relationship
Stressful Work Environment	Stressful Home Environment	Does not feel safe at home
Religion Affecting	Professional	Homemaker

What is your smoking status?

Current every day Smoker   Current some days Smoker   Former Smoker

Never smoked

FOR CURRENT SMOKER, what year did you start smoking? ___________________

Cigarettes   Cigars   Smokeless Cigarettes

FOR FORMER SMOKER, Year Quit _______________

How many years did you smoke: _______________

Do you encounter second hand smoke (passive smoker exposure)   Yes   No

Do you use Drugs?   Yes   No

Drug Use: Circle all that apply   None

Marijuana   Cocaine   Crack

Heroin   Illicit RX   Other

HIV High Risk Behavior   Yes   No

Caffeine use (drinks a day)   0   1   2   3   4   5+

Alcohol Use   Yes   No

Type of Alcohol ______________________

How many drinks a day   0   <1   1   2   3   4   5+

Have you felt the need to cut down on your alcohol use?   Yes   No

Have you been annoyed by complaints regarding your alcohol use?   Yes   No

Have you felt guilty regarding your alcohol use?   Yes   No

Have you needed an eye-opener in the morning?   Yes   No

Do you exercise regularly?   Yes   No

How many times per week do you exercise   1   2   3   4   5   6   7   8+

Type of exercise? ____

Seatbelt use 0% 25% 50% 75% 100%

Sun Exposure? Remote Rarely Occasionally Frequently

Pregnancy Confirmed by: Aid to Women Planned Parenthood School

Self Coastal Bend Women's Center

Occupation: Homemaker Outside Work Student

Education: (last grade completed)? ______________

Number of children at home? ______________

Hospital of Delivery? ____

Newborn's Physician ____

Husband/Father of baby? ____

Father of baby occupation? ____

Father of baby phone? ____

Comments regarding father of baby ____

Do you have a risk of Hepatitis B? Yes No

Are you immunized against Hepatitis B? Yes No

Do you have exposure to TB? Yes No

Do you have history of genital herpes? Yes No

Do you have a sexual partner with history of genital herpes? Yes No

Have you experienced a rash, viral or febrile illness since your last menstrual cycle?
Yes No

Do you have exposure to cat litter? Yes No

Chicken Pox Immune Status? History of disease/Immune Non-Immune History of Vaccine

History of Parvovirus (Fifth Disease)? Yes No

Occupational exposure to children? Daycare Teacher Other None

Do you have environmental exposure to X-rays? Yes No

Have you used medication, drugs, or alcohol since your last menstrual cycle? Yes No

Do you have environmental exposure to Chemicals/Other? Yes No

Do you accept blood or blood products? Yes No

If you have had a pap, what were the results? Normal Abnormal