[illegible]SONAL AND FAMILY HEALTH HISTORY

The purpose of this questionnaire is to identify any special needs you may have. Yours answers will remain confidential.

NAME ______________________ AGE ________ DATE OF BIRTH ____________________

ADDRESS ______________________________________
____

MARITAL STATUS M____ S____ D____ W____

SOCIAL SECURITY # ____________________

GRADE COMPLETED__________

HOME PHONE: ____________________

EMPLOYER ____________________

CELL PHONE: ____________________

EMERGENCY CONTACT NAME____________________

EMPLOYER PHONE____________________

EMERGENCY CONTACT PHONE____________________

LAST MENSTRUAL PERIOD__________________

PLEASE INDICATE BELOW IF YOU OR ANY OF YOUR CLOSE BLOOD RELATIVES HAVE EXPERIENCED ANY OF THE FOLLOWING:

	YOU	FAMILY
High Blood Pressure	________	________
Heart Trouble / Heart Attack	________	________
Diabetes	________	________
Brain Tumor	________	________
Seizures	________	________
Migraine Headaches	________	________
Scoliosis	________	________
Thyroid Problems	________	________
Adrenal Gland Problems	________	________
Pituitary Problems	________	________
Cushing's Disease	________	________
Bleeding Problems	________	________
Chronic Anemia	________	________
Sickle Cell Trait / Disease	________	________

PLEASE INDICATE BELOW IF YOU HAVE EVER EXPERIENCED OR BEEN TOLD THAT YOU HAVE ANY OF THE FOLLOWING:

	YOU
Rheumatic Fever	________
Scarlet Fever	________
Asthma	________
Bronchitis	________
Pneumonia	________
Hiatal Hernia	________
Ulcers	________
Gallbladder Problems / Stones	________
Crohn's Disease	________

	YOU	Husband
Irritable Bowel Syndrome	______	
Colitis	______	
Heart Murmur	______	
Phlebitis	______	
Varicose Veins	______	
Blood Clots in Legs or Lungs	______	
Hepatitis	______	
Jaundice	______	
Kidney Stones	______	
Kidney or Bladder Infection	______	
Lymphoma	______	
Other Cancer (Specify) ______	______	
Mononucleosis	______	
Encephalitis	______	
Measles	______	
Chicken Pox	______	
Gonorrhea	______	
Chlamydia	______	
Trichomoniasis	______	
Yeast Infections	______	
Herpes	______	______
Genital Warts	______	

USUAL MENSTRUAL CYCLE: *LENGTH* ______
DURATION ______ *AMOUNT* ______

ANY IRREGULAR BLEEDING ______

DID YOU HAVE ANY PROBLEMS BECOMING PREGNANT ______

HAVE YOU EVER HAD AN OPERATION ______
YEAR ______ *PROCEDURE* ______
HOSPITAL ______ *PHYSICIAN* ______

HAVE YOU EVER BEEN HOSPITALIZED ______
YEAR ______ *DIAGNOSIS* ______

HAVE YOU EVER HAD ANY SERIOUS ACCIDENTS ______

ARE YOU ALLERGIC TO ANY MEDICINES (SPECIFY) ______

HAVE YOU EVER DONATED BLOOD________________________

HAVE YOU EVER BEEN TESTED FOR HIV / AIDS______________

DO YOU SMOKE____ HOW MUCH BEFORE PREGNANCY_________________
SINCE PREGNANCY _____________________________

DO YOU DRINK BEER, WINE, OR HARD LIQUOR______________________________

DO YOU USE MARIJUANA_________COCAINE_________OTHER DRUGS_________

WHAT PRESCRIPTION OR OVER-THE-COUNTER MEDICATIONS DO YOU TAKE REGULARLY

____

DO YOU OWN A CAT___________________ DO YOU HANDLE THE KITTY LITTER______________

PREGNANCY HISTORY

NO	YEAR	SEX	WEIGHT	HOURS IN LABOR	PROBLEMS WITH PREGNANCY OR BIRTH (Indicate miscarriages or abortions here)
1					
2					
3					
4					
5					
6					
7					
8					

PATIENT NAME ______________________ SCREENING QUESTIONNAIRE ATE______________

	YES	NO
1. Will you be age 35 or older when you have children?	____	____
2. Have you or your partner or anyone in either of your families ever had:	____	____
Down's Syndrome	____	____
Spina Bifida or Meningomyelocele (open spine)	____	____
Hemophilia	____	____
Muscular Dystrophy	____	____
Cystic Fibrosis	____	____
3. Have you or your partner had a child born dead or alive with a birth defect not listed in question 2 above *If yes, describe* ______________________________	____	____
4. Do you or your partner have any close relatives who are mentally retarded or have birth defects? *If yes, list cause if known* ______________________________	____	____
5. Do you or your partner or a close relative in either of your families have any inherited genetic or chromosomal disease or disorder not listed above *If yes, describe* ______________________________	____	____
6. Have you or your partner had 3 or more spontaneous pregnancy losses (miscarriages, stillbirths, etc.?)	____	____
7. Do you or your partner have any close relatives descended from Jewish people who lived in Eastern Europe (Ashkenazi Jews)?	____	____
If yes, have either you or your partner been screened for Tay-Sacha disease? *If yes, indicate results and who was screened* ______________________________	____	____
8. Are you or your partner African American?	____	____
If yes, have either you or your partner, or any close relative ever been screened for sickle cell trait and found to be positive? *If yes, indicate results and who was screened* ______________________________	____	____
9. Do you or your partner have any close relatives descended from Mediterranean countries?	____	____
If yes, have you, or your partner, been screened for thalassemia (Cooley's anemia)? *If yes, indicate results and who was screened:* ______________________________	____	____
10. Do you drink alcoholic beverages? *If yes, describe how often and amount:* ______________________________	____	____
11. Do you take any medications either by prescription or those which can be purchased over the counter in a drug store *If yes, please list drugs and dosage schedule:* ______________________________	____	____
12. Have you ever been tested to determine if you are immune to rubella (German Measles)? *If yes, please indicate where and when tested and results of test:* ______________________________	____	____