Women Caring for Women OB/GYN
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HEALTH QUESTIONAIRE

Please circle the answer which best pertains to you:

Yes No Has your eyesight changed recently?
Yes No Do you have any eye pain or blurred vision early on the morning?
Yes No Do you have frequent sore throats or hoarseness?
Yes No Do you have frequent nosebleeds?
Yes No Have you ever had tuberculosis or any chest congestion?
Yes No Have you ever had close contact with a tuberculosis patient?
Yes No Had you ever had hay fever, asthma, hives, or any other allergic conditions?
Yes No Do you have a cough?
Yes No If so, do you cough up phlegm?
Yes No Has your cough worsened in the last six months?
Yes No Do you ever cough up blood?
Yes No Have you ever had rheumatic fever, high blood pressure or heart Disease?
Yes No Have you ever had pain, tightness or fullness in your chest?
Yes No Does your heart pound or skip beats?
Yes No Do you ever have distress, pain or shortness of breath when walking?
Yes No Do you smoke?
Yes No Have you ever smoked?
Yes No Do you need pillows or bolsters in order to sleep?
Yes No Do you suffer from severe headaches or pressure in the head?
Yes No Do you have dizzy spells or feel faint frequently?
Yes No Do you have cold hands or feet?
Yes No Is your appetite poor?
Yes No Do you have indigestion, heartburn, belching or stomach pain?
Yes No Have you ever vomited blood?
Yes No Have you ever had a stomach ulcer or duodenal ulcer?
Yes No Have your bowel movements or habits changed recently?
Yes No Have you ever had bloody or tarry (black) bowel movements or blood on the toilet tissue?

Yes No Have you ever had yellow jaundice, liver trouble, or gallstones?
Yes No Were you ever anemic?
Yes No Do you bruise or bleed easily?
Yes No Do you have any pain, stiffness or swelling in any muscles or joints?
Yes No Do you have trouble with your back?
Yes No Are you bothered by itching?
Yes No Have you had rashes or boils?
Yes No Do you have numbness, tingling, or weakness in any part of your body?
Yes No Were you ever unconscious or paralyzed?
Yes No Have you ever had fits or convulsions?
Yes No Do you urinate more often than usual in the day or night?
Yes No Have you had bloody urine?
Yes No Have you had cloudy urine?
Yes No Have you had any pain or burning with urination?
Yes No Do you sometimes loose control of your bladder, especially when coughing or sneezing?
Yes No Were you ever treated for syphilis, gonorrhea, or any other venereal Disease?
Yes No Are you ever unusually thirsty or hungry?
Yes No Have you ever had goiter?
Yes No Have you ever had any operations, broken bones or a serious injury?
Yes No Have you gained more than 10lbs in the last six month?
Yes No Have you lost more than 10lbs in the last six months?
Yes No Have you noticed any lumps, growths or sores?
Yes No Do you take any medication, laxatives, vitamins or other pills?
Yes No Do you have 2 or more alcoholic drinks, including beer and wine, a day?
Yes No Have you ever had a hernia rupture?
Yes No Have you ever been turned down for life insurance, employment, or the military?
Yes No Are you a nervous person?
Yes No Do you often feel tired?
Yes No Do you sleep poorly?
Yes No Do you often feel unhappy or depressed?
Yes No Have you ever had a nervous breakdown?
Yes No Have you ever taken any illegal drugs?
Yes No Have you ever smoked marijuana?