

# LASER VAGINAL REJUVENATION INSTITUTE OF THE INLAND EMPIRE

Date of Visit:
Dates Revised:

PLEASE FILL OUT FORM PRIOR TO  
YOUR VISIT

## HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential  
and will become part of your medical record.

Name (Last, First, M.I.):	<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Marital status:	<input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Previous or referring doctor:	Date of last physical exam:	

### PERSONAL HEALTH HISTORY

Childhood illness:	<input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio	
Immunizations and dates:	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Pneumonia
	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Chickenpox
	<input type="checkbox"/> Influenza	<input type="checkbox"/> MMR <i>Measles, Mumps, Rubella</i>

Reason for visit

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Surgeries		
Year	Reason	Hospital

Other hospitalizations other than pregnancy/delivery		
Year	Reason	Hospital

Have you ever had a blood transfusion?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Please turn to next page

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

**HEALTH HABITS AND PERSONAL SAFETY**

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

<b>Exercise</b>	<input type="checkbox"/> Sedentary (No exercise)		
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)		
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
<b>Diet</b>	Are you dieting?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	# of meals you eat in an average day?		
<b>Caffeine</b>	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea
	<input type="checkbox"/> Cola	# of cups/cans per day?	
<b>Alcohol</b>	Do you drink alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, what kind?		
	How many drinks per week?		
	Are you concerned about the amount you drink?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you considered stopping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever experienced blackouts?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Are you prone to "binge" drinking?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you drive after drinking?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Tobacco</b>	Do you use tobacco?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit	<input type="checkbox"/> Cigars - #/day
<b>Drugs</b>	Do you currently use recreational or street drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

<b>Sex</b>	Are you sexually active?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you trying for a pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Personal Safety</b>			
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

### FAMILY HEALTH HISTORY

ENTER "D" FOR DECEASED

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
<b>Father</b>			<b>Children</b>	<input type="checkbox"/> M	
				<input type="checkbox"/> F	
<b>Mother</b>				<input type="checkbox"/> M	
			<input type="checkbox"/> F		
<b>Sibling</b>	<input type="checkbox"/> M		<input type="checkbox"/> M		
	<input type="checkbox"/> F		<input type="checkbox"/> F		
	<input type="checkbox"/> M		<input type="checkbox"/> M		
	<input type="checkbox"/> F		<input type="checkbox"/> F		
	<input type="checkbox"/> M		<b>Grandmother</b>		
	<input type="checkbox"/> F		<i>Maternal</i>		
	<input type="checkbox"/> M		<b>Grandfather</b>		
	<input type="checkbox"/> F		<i>Maternal</i>		
<input type="checkbox"/> M		<b>Grandmother</b>			
<input type="checkbox"/> F		<i>Paternal</i>			
<input type="checkbox"/> M		<b>Grandfather</b>			
<input type="checkbox"/> F		<i>Paternal</i>			

### PERSONAL PAST HISTORY

<input type="checkbox"/> Fibroids	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Broken Bones
<input type="checkbox"/> Sexually Transmitted Diseases	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Stroke	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Blood Clots (legs/Lungs)	<input type="checkbox"/> Broken Bones
<input type="checkbox"/> Infertility	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Bowel Problems
<input type="checkbox"/> Reflux	<input type="checkbox"/> Lupus	<input type="checkbox"/> Chicken Pox
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cancer	<input type="checkbox"/> HIV

## GYNECOLOGIC HISTORY

Age at onset of menstruation:		
Date of last menstruation:		
Period every          days		
Heavy periods, irregularity, spotting, pain, or discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Length of periods          days		
Any changes in your periods?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a hysterectomy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a D&C??	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Number of lifetime sexual partners		
Present birth control method		
Do you do self breast examinations?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any problems with control of urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any hot flashes or sweating at night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Experienced any recent breast tenderness, lumps, or nipple discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had an abnormal pap smear?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

### DATE OF LAST PAP EXAM?

## OBSTETRICAL HISTORY

### NUMBER OF PREGNANCIES

### NUMBER OF MISCARRIAGES

No	BIRTH DATE	WEIGHT AT BIRTH	BABY'S SEX	TYPE OF DELIVERY	COMPLICATIONS
1.					
2.					
3.					
4.					

### NUMBER OF LIVING CHILDREN

### NUMBER OF ABORTIONS

## REVIEW OF SYSTEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

CONSTITUTIONAL	EYES	SKIN
<input type="checkbox"/> Weight loss	<input type="checkbox"/> Glasses/Contacts	<input type="checkbox"/> Rash
<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Earaches	<input type="checkbox"/> Sores
<input type="checkbox"/> Fever	<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> Moles
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Dry Skin
RESPIRATORY	CARDIOVASCULAR	GASTROINTESTINAL
<input type="checkbox"/> Painful Breathing	<input type="checkbox"/> Chest Pain or Pressure	<input type="checkbox"/> Frequent Diarrhea
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Difficulty Breathing with Exertion	<input type="checkbox"/> Bloody Stool

<input type="checkbox"/> Spitting up Blood	<input type="checkbox"/> Swelling of Legs	<input type="checkbox"/> Nausea/Vomiting
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Rapid Heartbeat	<input type="checkbox"/> Constipation
<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Involuntary Loss of Stool/Gas
<b>ENDOCRINE</b>	<b>GENITOURINARY</b>	<b>GENITOURINARY (CONTINUED)</b>
<input type="checkbox"/> Hair Loss	<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Incontinence (coughing/sneezing)
<input type="checkbox"/> Heat Intolerance	<input type="checkbox"/> Pain with Urination	<input type="checkbox"/> Abnormal Vaginal Discharge
<input type="checkbox"/> Cold Intolerance	<input type="checkbox"/> Urgency	<input type="checkbox"/> Abnormal Bleeding
<input type="checkbox"/> Abnormal Thirst	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Painful Periods
<input type="checkbox"/> Hot Flashes	<input type="checkbox"/> Incomplete Emptying	<input type="checkbox"/> Painful Intercourse
<b>MUSCULOSKELETAL</b>	<b>HEMATOLOGIC</b>	<b>PSYCHIATRIC</b>
<input type="checkbox"/> Joint Pain	<input type="checkbox"/> Frequent Bruises	<input type="checkbox"/> Post-partum Depression
<input type="checkbox"/> Muscle Pain	<input type="checkbox"/> Cuts do not stop bleeding	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Muscle Weakness	<input type="checkbox"/> Enlarged Lymph Glands	<input type="checkbox"/> Depression
<b>BREASTS</b>	<b>NEUROLOGICAL</b>	<b>NEUROLOGIC (CONTINUED)</b>
<input type="checkbox"/> Pain in Breasts	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Trouble Walking
<input type="checkbox"/> Nipple Discharge	<input type="checkbox"/> Seizures	<input type="checkbox"/> Memory Problems
<input type="checkbox"/> Lumps	<input type="checkbox"/> Numbness	<input type="checkbox"/> Frequent Headaches

**PLEASE DESCRIBE ANY PARTICULAR ISSUE THAT YOU WOULD LIKE TO BE ADDRESSED IN MORE DETAIL AT YOUR VISIT**