Patient Questionnaire

Name: Date:

Reason for visit: DOB:

PREVENTIVE HEALTH

	Date of last:	Results		Date of last:	Results
Mammogram		Normal ☐ Abnormal ☐	Dexa Scan		Normal ☐ Abnormal ☐
PAP		Normal ☐ Abnormal ☐	Colonoscopy		Normal ☐ Abnormal ☐

Abnormal Pap/Mammogram indicate dates and procedures performed:

PAST MEDICAL HISTORY

Arthritis	☐ Yes	Diabetes	type I ☐ or type II ☐	Seizures/Epilepsy	☐ Yes
Asthma	☐ Yes	Heart disease	☐ Yes	Skin disease	☐ Yes
Blood Clots	☐ Yes	Hepatitis	☐ Yes	Stroke	☐ Yes
Blood Transfusions	☐ Yes	High blood pressure	☐ Yes	Thyroid disease	☐ Yes
Bowel disorders	☐ Yes	Kidney/bladder problems	☐ Yes	Urinary incontinence	☐ Yes
Cancer	☐ Yes	Migraines	☐ Yes	Other: _____	
Depression	☐ Yes	Osteoporosis	☐ Yes		

SURGERIES:

Year	Description	Year	Description

CURRENT MEDICATION

Medication	Frequency of Dose	Medication	Frequency of Dose

Contraceptive History Current Method _____ Past methods_____

DRUG ALLERGIES	REACTION	DRUG ALLERGIES	REACTION

FAMILY HISTORY Have any of your close relatives had any of the following conditions?

Condition:	Relation to you	Maternal/Paternal	Age	Condition:	Relation to you	Maternal/Paternal	Age
☐ Breast cancer				☐ High blood pressure			
☐ Colon cancer				☐ Ovarian cancer			
☐ Diabetes type II				☐ Stroke			
☐ Diabetes type I				☐ Uterine cancer			
☐ Heart attack							

SOCIAL HISTORY

Marital Status: Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

Smoking: ☐ Yes ☐ No (# per day? _____) Alcohol: ☐ Yes ☐ No (#/week?_____) Illegal drugs: ☐ Yes ☐ No

Exercise: ☐ Yes ☐ No _____ times per week Activity: _____

Occupation:_____ Significant others name & occupation: _____

Patient Questionnaire Continued

MENSTRUAL HISTORY

Age at 1st period _____

1st day of last period _____ (date bleeding began)

Duration of bleeding _____ (# of days bleeding)

Period interval (1st day to 1st day) _____ (# of days)

Menstrual Flow: ☐ Mild ☐ Moderate ☐ Heavy

Menstrual Cramps: ☐ Mild ☐ Moderate ☐ Severe

Sexual History

Age of 1st intercourse: _____ Sexual preference: ☐ Heterosexual ☐ Homosexual ☐ Bisexual

# of lifetime sexual partners: _____ Pain with intercourse: ☐ Yes ☐ No

History of Sexual Abuse/Assault: ☐ Yes ☐ No

Have you received the Gardasil Vaccine: ☐ Yes ☐ No If yes when/where: _____

History of STI: Chlamydia ☐ Gonorrhea ☐ Herpes ☐ HPV ☐ Trichomonas ☐

OBSTETRICAL HISTORY

Total # of Pregnancies: _____ Full Term Births: _____ Premature Births: _____ Abortions: _____

Miscarriages: _____ Ectopics: _____ Multiple Births (twins) : _____ Living Children: _____

Date of Delivery	Weeks Preg.	Weight	Sex	Type of Delivery	Complications
1)					
2)					
3)					
4)					
5)					
6)					

PLEASE CHECK (X) IF ANY OF THE FOLLOWING SYMPTOMS APPLY TO YOU ***CURRENTLY***

CONSTITUTIONAL

- ☐ Fatigue
- ☐ Fever
- ☐ Unexplained weight gain
- ☐ Weight loss in past 3 months

EYES

- ☐ Blurred or double vision

BREASTS

- ☐ Pain in breast
- ☐ Discharge
- ☐ Lumps

CARDIOVASCULAR

- ☐ Swelling of feet or ankles
- ☐ Irregular heart beat
- ☐ Murmur
- ☐ Pain in chest

RESPIRATORY

- ☐ Shortness of breath
- ☐ Coughing up of sputum
- ☐ Abnormal sputum production

GASTROINTESTINAL

- ☐ Frequent diarrhea
- ☐ Bloody stool
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation

PSYCHIATRIC

- ☐ Depression
- ☐ Anxiety

GENITOURINARY

- ☐ Blood in urine
- ☐ Pain with urination
- ☐ Urgency
- ☐ Frequency of urination
- ☐ Frequent urination only at night
- ☐ Stress incontinence
- ☐ Abnormal periods
- ☐ Painful intercourse

SKIN

- ☐ Rash

ENDOCRINE

- ☐ Night sweats
- ☐ Hot flashes