

PATIENT QUESTIONNAIRE

How did you hear about our practice? _____

Do you currently work outside the home? Yes No

Current Occupation / Type of Employment: _____

Past Medical History

1) Your overall general health could best be described as:

Excellent Good Average Poor

2) Do you regularly see another physician? Yes No

Name: _____

Name: _____

3) Please list any medication which you are currently taking (including over the counter)

Medication	Strength	Frequency	Doctor Prescribing
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

4) Please list all medications to which you have had an allergic reaction:

_____ Type of reaction: _____

_____ Type of reaction: _____

5) Please list all surgeries:

Type of Surgery	Date	Type of Surgery	Date
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_____	_____	_____	_____
_____	_____	_____	_____

6) Have you ever had a blood transfusion? Yes No

7) Do you smoke? Yes No How many packs/day? _____ How many years? _____

8) Have you ever been diagnosed with any of the following conditions?

- | | |
|-----------------------------------|---|
| _____ Eye Disorders | _____ Bowel disorders, colitis, spastic |
| _____ Ear, nose, throat disorders | _____ Kidney infections or stones |
| _____ Asthma, chronic bronchitis | _____ Diabetes |
| _____ Tuberculosis | _____ Thyroid disorders |
| _____ Heart Problems | _____ Bleeding tendencies |
| _____ Mitral valve prolapse | _____ Anemia |
| _____ High blood pressure | _____ Arthritis |
| _____ Breast cysts, biopsies | _____ Seizures, neurologic conditions |
| _____ Stomach problems, ulcers | _____ Depression requiring therapy |
| _____ Gallbladder disease | _____ Skin diseases |
| _____ Liver disease, Hepatitis | _____ Cancer |

Others: _____

9) Have you ever had a mammogram (breast x-ray)? ____ Most Recent: ____/____/____
Is there a family history of cancer (Breast, ovum, uterus, colon, other)? _____
Relationship / Type? _____

10) Is there positive family history of any disease? _____

Gynecologic & Obstetric History

(even if you have had a hysterectomy or are now post-menopausal, please provide your history as best as you recall)

Current Status:

1) Current Age: _____ Total times pregnant: _____ Single: _____
Total deliveries: _____ Married/Partnered: _____
Spontaneous Miscarriages: _____ Separated: _____
Elective Abortions: _____ Divorced: _____
Total Living Children: _____ Widowed: _____

2) Are you now sexually active? _____

3) Method of Contraception?

____ Birth Control Pills If "Yes", what kind? _____
____ Condoms _____ Spermicides
____ Diaphragm _____ Sponge
____ IUD _____ Hysterectomy
____ Tubal Ligation _____ Vasectomy
____ Never been able to conceive
____ Other: _____

4) Are you on any female hormones?

If yes, what kind? _____

5) Menstrual History

Age of First Period _____ Date of Last Period: _____
Usual length of flow _____ to _____ days Cycle Length (ex: 28 days) _____ days
Are your periods ____ Heavy ____ Average ____ Light
Do you bleed between periods? _____
Do you consider your menstrual cramps severe? _____ Pain Meds? _____

6) Have you ever been diagnosed with any of the following:

____ Abnormal Pap Smear _____ Tubal Infection _____ Dysplasia of cervix
____ Pelvic Inflammatory Disease _____ Fibroids, uterine _____ Ovarian Cysts
____ Venereal Disease _____ HPV Infection _____ Herpes
____ Cancer (Please indicate type): _____
____ Other: _____

7) Date of Last Pap Smear: ____/____/____

8) Have you ever had any gynecologic surgeries?

____ D & C _____ Hysterectomy _____ Tubal Ligation
____ C-Section (#: _____) _____ Other: _____

9) Do you believe you need to be checked for a vaginal infection today? _____

10) Do you experience pain with intercourse? _____ Long standing or recent? _____
Has it reached a point of being a significant problem? _____
Do you bleed or spot after intercourse? _____

11) Please list the main reason(s) for your visit today:

_____ Routine, Well Woman Physical Exam

_____ Other: