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PATIENT QUESTIONNAIRE

Date: _____
 Name: _____
 Preferred Name: _____
 Birth Date/Place: _____

OFFICE USE
 Age: _____ G _____ P _____
 S M Sep Div W
 LMP: ____/____/____
 Contra: _____
 Allergies: _____

Reason for today's visit:

How long has this gone on? 1 day ____ 1 week ____ 1 month ____ 1 year ____ 1+ years ____

OBSTETRICAL HISTORY:

Pregnancies: List in sequence from first to most recent, including miscarriages and abortions

Date of Birth (month/day/year)	Baby's Sex (Circle)	Baby's Weight	Complications: (Such as high blood pressure, diabetes, transfusions, surgeries, etc.)
/ /	Male Female		
/ /	Male Female		
/ /	Male Female		
/ /	Male Female		
/ /	Male Female		

MEDICAL HISTORY:

List any illnesses, current or past, under the care of a physician (i.e, diabetes, etc.)

Year	Diagnosis	Medications	Year	Diagnosis	Medications

Have you ever had any of the following? (circle applicable)

- asthma depression diabetes heart murmur hepatitis
 high blood pressure migraine headaches mononucleosis (mono) seizures
 thyroid problem transfusion of blood or blood products tuberculosis

SURGICAL HISTORY: (list all operations giving Date, City and Procedure)

Date	City	Procedure

Have you ever had any hospitalizations other than above? Yes No (Circle)
 (If yes, list on back of page)

Have you ever had any major injuries not listed above? Yes No (Circle)
 (If yes, list on back of page)

ALLERGIES: (include food and environmental allergies)

Allergy	Reaction

MEDICATIONS:

List all medications you are presently taking, including vitamins/minerals/herbal supplements:

GYNECOLOGICAL HISTORY:

Last menstrual period began LMP: ____/____/____
 Age when menses began _____
 How many days do you bleed? _____
 How many days between first days of each period? _____
 Do you clot with your menses? Yes No (Circle) _____
 Is your menses regular? Yes No (Circle) _____
 Have you had any recent
 change in your cycle? Yes No (Circle) _____
 Date of last Pap smear: _____
 Have you ever had an
 abnormal Pap smear? Yes No (Circle) _____
 If yes, when and what therapy did you receive? _____

Do you have pain with your menses? Yes No (Circle) _____
 Do you have pain with ovulation? Yes No (Circle) _____
 Are you having sexual relations? Yes No (Circle) _____
 Are you having intercourse? Yes No (Circle) _____
 Do you have pain with intercourse? Yes No (Circle) _____

Do you get satisfaction from

your sexual relations? Yes No (Circle) _____
 Do you bleed between periods? Yes No (Circle) _____
 Do you bleed after intercourse? Yes No (Circle) _____
 Do you bleed from your rectum? Yes No (Circle) _____

Do you have a vaginal discharge? Yes No (Circle) _____
 Do you have any itching? Yes No (Circle) _____
 Do you have any burning? _____
 Have you ever had a pelvic infection (PID)? Yes No (Circle) _____

Have you ever had any of the following: (Circle if yes)

Gonorrhea Chlamydia Herpes
 Syphilis Genital warts

Has your partner had any of the above? Yes No (Circle)
 (If yes, list on back)

What birth control method(s) are you currently using? (Circle applicable)

Cervical Cap Foam or Jelly alone Sponge Condoms
 IUD Tubal Ligation Diaphragm Pill
 Patch Nuva Ring Vasectomy DepoProvera
 Rhythm Abstinence Other: _____

Are you satisfied with your current method of birth control? Yes No (Circle) _____
 Have you ever used the Pill? Yes No (Circle) _____
 Have you ever used an IUD? Yes No (Circle) Type? _____

Do you desire to have children in the future? Yes No (Circle) _____

Have you had any of the following? (explain on back)
 Endometriosis? Yes No (Circle)
 Fibroids? Yes No (Circle)
 Ovarian cysts or tumors? Yes No (Circle)

Do you check your breasts every month? Yes No (Circle) _____
 Have you ever had a mammogram? Yes No (Circle)
 If yes, when and where? _____

Have you ever had a breast biopsy? Yes No (Circle) _____
 Do you have discharge from your breasts? Yes No (Circle) _____
 Do you have any lump(s) in your breasts? Yes No (Circle) _____
 Do you notice unusual hair growth on your breasts, face, or elsewhere? Yes No (Circle) _____

Are you bothered by hot flashes? Yes No (Circle) _____
 Do you notice vaginal dryness? Yes No (Circle) _____
 Do you have night sweats? Yes No (Circle) _____
 Do you feel anxious/moody/irritable? Yes No (Circle) _____

Do you have frequent mood swings/irritability? Yes No (Circle) _____
 Have you taken estrogens? Yes No (Circle) _____
 Other problems? Yes No (Circle) _____

Are you able to fall asleep and

awaken alert and refreshed? Yes No (Circle) _____

Do you have trouble sleeping? Yes No (Circle) _____

If so, describe: _____

Are you not able to sleep because of feeling hot? Yes No (Circle) _____

Are you able to fall asleep after you are awakened? Yes No (Circle) _____

Do you ever feel your mind is "on" and you can't turn it off? Yes No (Circle) _____

How often do you urinate during the day? _____

Do you have a strong urge to urinate? Yes No (Circle) _____

Do you have to hurry to the toilet? Yes No (Circle) _____

Does the sight or sound or feel of running water cause you to lose urine? Yes No (Circle) _____

Are you ever unaware that you are losing your urine? Yes No (Circle) _____

Do you lose urine when you cough, laugh or sneeze? Yes No (Circle) _____

Large or small amounts? Large Small (Circle) _____

Do you have to wear a pad because of urine leakage? Yes No (Circle) _____

Do you have a feeling of pressure or bearing down? Yes No (Circle) _____

Do you have a bulging from your vagina? Yes No (Circle) _____

FAMILY HISTORY:

Please list your natural parent's current ages, whether they are still alive or deceased, and any major illnesses they have or had. (Check here if adopted, no family history)

	Alive/Deceased? (Circle)	Current Age or Age at Death	Illnesses
Mother	Alive Deceased		
Father	Alive Deceased		
Siblings	Alive Deceased		

Do you have a family history of any of the following?

	Relationship(s)	Comments
High Blood Pressure	Yes No (Circle)	
Heart Attack	Yes No (Circle)	
Stroke	Yes No (Circle)	
Diabetes	Yes No (Circle)	
Breast Cancer	Yes No (Circle)	

Ovarian Cancer	Yes No (Circle)		
Colon Cancer	Yes No (Circle)		
Other Cancers	Yes No (Circle)		
Birth Defects	Yes No (Circle)		
Osteoporosis	Yes No (Circle)		
Alcoholism/Addictions	Yes No (Circle))		
Mental Health Problems	Yes No (Circle)		
Other Depression	Yes No (Circle)		
Anxiety	Yes No (Circle)		
Other	Yes No (Circle)		

SOCIAL HISTORY:

- Do you have a regular exercise program? Yes No (Circle) _____
- Have you ever smoked cigarettes? Yes No (Circle) _____
- Do you smoke now? Yes No (Circle) _____
- If yes, how much/day? _____
- Do you use other recreational drugs? Yes No (Circle) _____
- Do you drink alcohol? Yes No (Circle) _____
- If yes, how much/day? _____
- Are you currently having problems with your marriage or partner? Yes No (Circle) _____
- Do you wish to discuss any of the above answers? Yes No (Circle) _____
- Have you ever lived out of the United States? Yes No (Circle) _____
- Where/when? _____

Please add any questions or comments below or on the back. Let us know if there is there any specific health information you are seeking.

Thank you for filling out this lengthy, detailed questionnaire. It helps us a great deal.