Patient Questionnaire

Thank you for completing this form. Our office is transitioning to an electronic health record as required by the new health care laws. Whether you are a new patient to our office or have been a long-term patient, we ask that you take the time to fill out this questionnaire in as much detail as possible. The more information we have about you, the better care we can take of you. Thank you for your time.

Name: _____ **Date of Birth:** _____ **Date:** ____

Why are you here today? _____

_____

Were you referred to us by another physician? _____ Name/Office? _____

Reproductive History:

First day of last period _____ Age periods began? ____ How many days does your period last? _____

How many days between the start of one period to the start of the next? _____

Bleeding in-between your periods? _____

How heavy is your period? Light_____ Moderate_____ Heavy_____

Do you have pain with your periods? Mild_____ Moderate_____ Severe_____

When was your last pap smear? _____ Have you ever had an abnormal pap smear?___ When?____

Have you ever had a colposcopy? _____ LEEP/Cone procedure of the cervix? _____

Have you ever had: Chlamydia____ Gonorrhea____ Herpes____ Syphilis____ Trichomonas____
Genital Warts___ Other STDs_____

Have you ever had sex? _____ How many sexual partners have you had? _____

Have your sexual partners been: Men _____ Women_____ Both _____

What do you currently use for birth control? Pill____ Ring____ Patch____ Depo-Provera____
Implanon____ T ubal____ Essure____ Adianna____ Vasectomy____ Condoms____

Natural Family Planning____ Nothing____ Other method_____

Have you ever been diagnosed with: Endometriosis_____ Fibroids_____ Infertility_____

Allergies: (please include medications, supplements, foods, environmental).

Allergy		Reaction	Allergy		Reaction
1			4		
2			5		
3			6		

Are you allergic to: Latex ____ Shellfish/iodine____ Eggs____

Current Medications: (please include any herbs, supplements and vitamins).

Medication	Dose	Prescribed by

Pregnancy History

Please list all your pregnancies in order (include miscarriages, ectopic pregnancies, abortions, etc.).

#	Date	What happened? (Vaginal, C-Section, miscarriage, ectopic, abortion)	How many weeks/ months were you? (Full term, preterm?)	Sex (M/F	Weight	Complications (Hypertension, Toxemia, Diabetes, etc.)	Hospital name
1							
2							
3							
4							
5							
6							

Social History:

Have you ever smoked? No___ Yes___ How much?____ How long for?_____Quit when?____

Have you ever used alcohol? No___ Yes___ How much?____ How often?_____ Quit_____

Have you ever used street drugs, or misused prescription drugs? No____ Yes____ Which?____

Are you: single____ married____ divorced____ widowed____ other_____

Occupation: _____ **Educational level:**_____

Personal and Family Medical History: Have you or any family members had any of these medical problems? Please give as much detail about the condition, and who had it.

Disease/Illness	You	Family	Please Explain
High Blood Pressure			
Diabetes			
Heart Disease/Stroke			
Lung Disease/Asthma			
Breast/Ovarian Cancer			
Cervical/Uterine Cancer			
Colon Cancer			
Other Cancers (specify)			
Thyroid Disease			
Kidney Disease/Stones			
Blood Clots (in legs, lungs)			
Bleeding Disorders			
Thyroid Disease			
Bowel Problems			
Stomach Ulcers/Reflux			
Liver Disease/Hepatitis			
Seizures/Neurologic			
Eye Disease/Glaucoma			
Arthritis/Bone/Muscle			
Mental Illness			
Eating Disorder			
Autoimmune (lupus etc.)			
Serious Infections (TB, HIV/AIDs, MRSA, etc.)			
Measles/ Chicken Pox			
Genetic/Inherited Disease			
Anemia			
Domestic Abuse/Rape			
Blood Transfusions			
Other			

Surgical History: Please list all surgeries that you have had. Include Cesareans, minor surgeries, etc.

Procedure/Operation	Date	What was removed?	Where?

Have you ever been diagnosed with sleep apnea? _____

Have you or any family members ever had problems with anesthesia (explain)? _____

Have you ever been told to use an antibiotic prior to surgery? _____

REVIEW OF SYSTEMS

NAME:_____ DATE OF BIRTH:_____

Please mark any items you are experiencing today:

CONSTITUTIONAL
- ☐ Fatigue
- ☐ Fever
- ☐ Chills
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Loss of Appetite
- ☐ Other:_____

BREASTS
- ☐ Lumps
- ☐ Tenderness
- ☐ Swelling
- ☐ Redness
- ☐ Nipple Discharge
- ☐ Abnormal changes in breasts
- ☐ Other:_____

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Irrgeular heart rate
- ☐ Rapid heart rate
- ☐ Fainting/passing out
- ☐ Lightheadedness
- ☐ Other:_____

RESPIRATORY
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Cough
- ☐ Other:_____

PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression
- ☐ Difficulty sleeping
- ☐ Suicidal or homicidal thoughts
- ☐ Other:_____

GASTROINTESTINAL
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Abdominal Pain
- ☐ Blood in stools
- ☐ Hemorrhoids
- ☐ Other:_____

GENITOURINARY
- ☐ Urgency
- ☐ Frequency
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Incontinence
- ☐ Decreased libido
- ☐ Painful intercourse
- ☐ Irregulary periods
- ☐ Painful periods
- ☐ Very heavy periods
- ☐ Vaginal Discharge
- ☐ Bleeding after sex
- ☐ Infrequent or no periods
- ☐ Possible pregnancy
- ☐ Significant PMS
- ☐ Other:_____

ENDOCRINE
- ☐ Nipple discharge
- ☐ Loss of hair
- ☐ Acne
- ☐ Abnormal hair growth
- ☐ Other:_____