Name:___________________________

Patient History Questionnaire

Reason for Visit: ☐ Annual ☐ Discuss a problem Date: ______________________
Referred by: ☐ Friend ☐ Insurance company ☐ Internet ☐ Physician: __________________

Issues/Questions I would like to discuss today: ___________________________________
____
____

Well-woman update: (record the date) Primary Care Physician:______________________
Last Pap smear: ___________________ Any abnormal Pap smears? ☐ Yes ☐ No
If yes, any treatment for cervix? (circle treatment) LEEP, Laser, Cryo/freezing, Cone Biopsy
Cholesterol Screening: ______________ Diabetes Screening: _______________________
Colonoscopy:______________________ Bone Density Screening: ___________________
Mammogram: ______________________ HPV/Gardasil Vaccine series completed?
☐ Yes ☐ No

Medical History: Do you now or have you ever had:

☐ Anemia
☐ Asthma
☐ Bleeding disorder
☐ Blood transfusion
☐ Bone/Joint disease
☐ Cancer (type?)______________
☐ Sexually transmitted disease (Chlamydia, Gonorrhea, Herpes, etc) ________________
☐ Deep Vein Thrombosis
☐ Drug abuse/ dependence
☐ Depression/Anxiety
☐ Diabetes (Type I or II)
☐ Elevated cholesterol
☐ Endometriosis
☐ GERD/Reflux
☐ Gastrointestinal problems
☐ Heart problems
☐ Hepatitis/Liver disease
☐ HIV
☐ High blood pressure
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Migraines
☐ Osteopenia/Osteoporosis
☐ Seizures
☐ Sleep Apnea

Surgeries/Hospitalizations:

____
____
____
____
____
____

Medications: (list)

____
____
____
____
____
____

Allergies:

____
____
____
____
____
____

Menstrual History:

- How old were you when you first got your period? ___________________
- First day of last period (date): ________
- How frequently do your periods occur? Every _____ days
- Are you periods regular or irregular?
- How long do your periods last? __days
- Any problems with your periods?
  ☐ No ☐ Yes __________________
- What are you currently using to prevent pregnancy

Gynecologic history:

- Have you ever been sexually active?
  ☐ Yes ☐ No
- How many sexual partners have you had in your lifetime? ___________________________
- Do you currently have a sexual partner?
  ☐ No ☐ Yes (☐ Male ☐ Female)
  If yes, how long have you been with this partner? ___________________________
- Do you have any concerns about your sexual activity that you'd like discuss today?

Pregnancy History:

___ Total pregnancies
___ Live births
___ Miscarriages
___ Abortions
___ Vaginal births
___ Cesarean

Any pregnancy complications?
☐ Pre-eclampsia ☐ Diabetes
☐ Other _____________

Are you currently trying to get pregnant?
☐ Yes ☐ No

Social History:

Occupation: ________________
Marital Status: ______________
Exercise (type/freq) __________
Smoke _____ Cig/day _____
Alcohol _____ Drinks/wk_____
Drug use ________________

Family History (e.g. Diabetes, Heart disease, Cancer (type), DVT, osteoporosis):

Mother: _____________________________
Father: ___________________________________
Maternal Grandparent: ________________
Paternal Grandparent: ______________________
Sibling: _____________________________
Other Relative: _____________________________

Review of Symptoms (circle symptoms):

- Blood/Lymphatic: easy bruising, bleed easily, enlarged lymph nodes
- Breast: Masses, nipple discharge
- Cardiovascular: palpitations, chest pain
- Endocrine: hair loss, temperature intolerance, excessive hair growth
- Gastrointestinal: bloating, constipation, diarrhea, bloody stool, nausea
- General: fatigue, fever, weight change
- Musculoskeletal: back pain, joint pain
- Neurological: Dizziness, headaches, vision changes
- Psychiatric: anxiety, depression, insomnia
- Pulmonary: Cough, shortness of breath
- Skin: Rash, warts
- Urinary: pain with urination, blood in urine, frequency, incontinence