

Patient Name _____

Date _____

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

PLEASE FILL OUT COMPLETELY, TO THE BEST OF YOUR ABILITY

Reason for today's visit: _____

PERSONAL HEALTH HISTORY

- Anxiety /Depression
- Arthritis
- Asthma
- Bleeding
- Blood Clots
- Cancer
- Diabetes
- Gastrointestinal Disease
- Heart Disease
- Hepatitis

- Blood Transfusion
- High Blood Pressure
- High Cholesterol
- HIV
- Kidney Disease
- Liver Disease
- Mental/Nervous Disease
- Myocardial Infarction/ Heart Attack
- Peptic Ulcer Disease
- Stroke
- STDs – type? _____
- Thyroid Disease
- Tuberculosis

List any other Doctors you see and reason

ALLERGIES TO MEDICATIONS _____ REACTION _____

Medication name & strength you are currently taking:

Name _____	Reason _____	Doctor that prescribed _____
Name _____	Reason _____	Doctor that prescribed _____
Name _____	Reason _____	Doctor that prescribed _____
Name _____	Reason _____	Doctor that prescribed _____
Name _____	Reason _____	Doctor that prescribed _____

PREFERRED PHARMACY _____

SURGICAL HISTORY

Type _____	Date _____	Reason _____
Type _____	Date _____	Reason _____
Type _____	Date _____	Reason _____
Type _____	Date _____	Reason _____
Type _____	Date _____	Reason _____
Type _____	Date _____	Reason _____

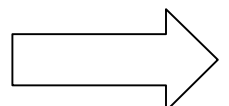
PREGNANCY HISTORY

Total number of pregnancies _____ Deliveries _____ Miscarriages _____ Abortions _____

of vaginal deliveries _____ # of cesarean sections _____ Live children _____

Problems in past pregnancies _____

CONTINUED ON BACK



MENSTRUAL HISTORY

Primary method of contraception _____
Last menstrual period ____/____/____ Age you started having periods? _____
How often do you have periods? _____
How long are your cycles? (days you bleed) _____
How is the flow? _____
Cramps or pain associated with your period? _____

FAMILY HISTORY -specify(maternal grandmother, father, sister, etc)

Colon Cancer _____	Heart Problems _____
Breast Cancer _____ Age _____	Thyroid Problems _____
Ovarian Cancer _____	Osteoporosis _____
Diabetes _____	Other _____
Hypertension _____	Other _____

SOCIAL HISTORY

Marital status (circle): Married Divorced Single In current relationship Widowed
Currently sexually active? _____ # of partners in past 12 months _____
Orientation _____ Last time you were checked for STDs _____
Employed at/ Student/Stay at home mom? _____
Do you use recreational drugs? _____ Type? _____
Do you drink alcohol? _____ How much? _____ How often? _____
Do you use tobacco products? _____ Type? _____ How much? _____
Do you use caffeine?(coffee, tea, soft drinks, or energy products) _____ How many per day? _____
Do you exercise? _____ How many times a week? _____

HEALTH MAINTENANCE/IMMUNIZATION HISTORY

Date of last Pap Smear ____/____/____ Was it normal? _____
Have you ever had an abnormal Pap Smear? _____ When? _____
Have you ever had a bone density scan? _____ Result: _____
Date of last mammogram ____/____/____
Have you ever had an abnormal mammogram? _____
Have you ever had a colonoscopy? ____ yes, ____ no. If yes, when? ____/____/____
When was your last tetanus (Td) vaccine? _____
When was your last pertussis (Tdap) vaccine? _____
Have you had the HPV (human papilloma virus) vaccine? ____ yes, ____ no.

Additional Comments _____

-----Office Use Only-----		
W _____	UPT _____	_____
H _____	UA _____	_____
BP _____	FP _____	_____
BSE _____		_____

