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_____

Breast Cancer_____Age_____

Ovarian Cancer_____

Diabetes_____

Hypertension_____

Heart Problems_____

Thyroid Problems_____

Osteoporosis_____

Other_____

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 _____ _____