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PATIENT HISTORY QUESTIONNAIRE

All information is strictly confidential and will be released only with your written permission.

Name _____ Age_____ Today's Date _____

Height _____Weight _____

Problems/Reasons for your visit:_____

Have you ever had:

Anemia	Y	N	Epilepsy or seizures	Y	N
Alcoholism	Y	N	Heart trouble or disease	Y	N
Arthritis	Y	N	Hepatitis	Y	N
Asthma	Y	N	High blood pressure	Y	N
Bleeding problems	Y	N	Migraine headaches	Y	N
Blood clots	Y	N	Seasonal allergies, hay fever	Y	N
Blood transfusion	Y	N	Stroke	Y	N
Birth defects	Y	N	Thyroid disease/goiter	Y	N
Cancer	Y	N	Ulcers	Y	N
Depression	Y	N	Osteoporosis	Y	N
Diabetes	Y	N	Glaucoma	Y	N
			Gallbladder problems	Y	N

Other Medical Problems _____

_____

_____

Medications (including non-prescription medications or supplements)

Currently Take:_____

_____

Allergies and reactions: Please list _____None

Name of Drug/Item:_____

_____

Pregnancy History: Number of pregnancies _____ Full term deliveries _____ Premature deliveries_____
Miscarriages _____ Abortions _____ Ectopic (tubal) _____ Living children _____

Deliveries: Year M/F Birthweight Weeks Pregnant Complications

1. _____
2. _____
3. _____
4. _____

Surgical and Hospitalization History (other than childbirth)

Surgery or Illness: **Date:** **Complications:**

_____

_____

_____

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Gynecologic History

Date of last menstrual period:_____

Date of previous menstrual period: _____

Is flow heavy, medium, or light?_____

Do you usually take medicine for cramps?	Y	N
Spotting between periods?	Y	N
Do you do self breast exams monthly?	Y	N

Date of last Pap smear:_____

Date of last mammogram:_____

Did your mother take DES when pregnant?	Y	N

Have you ever had or do you now have:

Abnormal Pap smear	Y	N
Breast discharge	Y	N
Breast lumps	Y	N
Ovarian cyst	Y	N
Endometriosis	Y	N
Infertility	Y	N
IUD	Y	N
Pelvic pain	Y	N
Painful intercourse	Y	N
Sexual problems	Y	N
Vaginal dryness	Y	N
Yeast infection	Y	N
Chlamydia	Y	N
Herpes	Y	N
Condyloma (venereal warts or HPV)	Y	N
Gonorrhea	Y	N
Syphilis	Y	N
Trichomonas	Y	N
Other vaginal infection	Y	N
Pelvic infection	Y	N
Urinary tract (bladder) infection	Y	N
Urinary incontinence (leakage)	Y	N
Hot flashes	Y	N
Night sweats	Y	N
Bleeding since menopause	Y	N
Bleeding between periods	Y	N
Are you sexually active?	Y	N
Are you currently using contraception?	Y	N

Method:_____

Other gynecologic problems: _____

_____

Personal Habits

Do you smoke or chew tobacco?	Y	N

No. packs/day:_____

When did you start?_____

Have you ever smoked in the past?	Y	N

Date started:_____

Date stopped:_____

Alcoholic drinks

No. /day:_____No. /week:_____

Ever had a drinking problem?	Y	N
Ever had a drug problem?	Y	N
Ever used intravenous drugs?	Y	N

Date last used:_____

Do you exercise regularly?	Y	N

What do you do?_____

How often?_____

Family History (Blood Relatives)

Cancer		
Breast	Y	N
Colon (Intestine)	Y	N
Ovarian	Y	N
Other	Y	N
Diabetes	Y	N
Blood clots	Y	N
High blood pressure	Y	N
Heart disease	Y	N
Kidney disease	Y	N
Stroke	Y	N
Thyroid disease	Y	N
Birth defects	Y	N
Blood disease/anemia	Y	N
Mental disorders	Y	N
Alcoholism	Y	N
Alzheimer's disease	Y	N
Osteoporosis	Y	N

Patient Signature and Date:

_____