Maarouf **PATIENT QUESTIONNAIRE** **Nanda**

Name: ______________________ **Date:** ______________________

Since your last visit to our office, your life may have changed and this may affect your health. Please help us to provide the best health care for you by completing this short questionnaire.

Please list all medication allergies: ______________________

Please list all medications you are currently taking with the dosage and number of times per day it is taken. (Include prescription, over-the-counter medications, vitamins, supplements, and herbal remedies.)

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	Circle One		If Yes, Please Specify
Are you having problems at home?	No	Yes→	
Are you interested in AIDS testing?	No	Yes→	
Do you have any concerns about depression?	No	Yes→	
Have you had any recent illnesses or surgeries?	No	Yes→	
Are you concerned with violence in your home?	No	Yes→	
Do you have any questions about safe sex or sexually transmitted diseases?	No	Yes→	
Have you ever been sexually, physically, or emotionally abused?	No	Yes→	

Does anyone in your family have breast, ovarian, colon or uterine cancer? No Yes

If yes, specify who ______________________

Your Pap results will be emailed unless other wise requested.

Email ______________________@______________________