

This questionnaire is confidential and will be considered part of your medical record.

The accurate completion of this form will be of value in evaluating your medical history. Thank you

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Today’s Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Nickname**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Age** \_\_\_\_\_ **Birth date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Occupation** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Telephone (H)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**(W)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**(C)**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email address**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May we use email to inform you of results? **Yes/No**

**Pharmacy/Address/Phone#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

What is the reason for your visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your weight? \_\_\_\_\_\_\_\_\_ height? \_\_\_\_\_\_\_\_\_

**Primary Care Provider:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check the conditions that you have now or have had:**

\_\_\_Breast cancer \_\_\_Heart disease \_\_\_Abnormal Pap Smears

\_\_\_Cervical /Ovarian/Uterine cancer \_\_\_Heart murmur \_\_\_Vaginal infections

\_\_\_Abnormal mammogram \_\_\_Mitral valve prolapse \_\_\_Pelvic Inflammatory Disease

\_\_\_Breast biopsy \_\_\_Hypertension \_\_\_Venereal warts/HPV

\_\_\_Fibrocystic breast \_\_\_High cholesterol \_\_\_HIV/AIDS

\_\_\_Ovarian cysts \_\_\_Kidney stones/disease \_\_\_Hepatitis

\_\_\_Uterine fibroids \_\_\_Liver/gallbladder disease \_\_\_Herpes

\_\_\_Bleeding problems \_\_\_Osteoporosis \_\_\_Gonorrhea/Chlamydia

\_\_\_Blood clots/DVT \_\_\_Thyroid disease \_\_\_Syphilis

\_\_\_Endometriosis \_\_\_Ulcer disease \_\_\_Trichomonas

\_\_\_Arthritis \_\_\_Chicken Pox \_\_\_Major accident

\_\_\_Bronchitis \_\_\_Rubella/German measles \_\_\_Depression/Anxiety

\_\_\_Epilepsy/Seizures \_\_\_Asthma \_\_\_Other psychological illness

\_\_\_Diabetes \_\_\_Other illness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you still having periods? **Yes/No** Date of last period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If no when did they stop? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If yes are they: **Regular / Irregular**

Number of days of flow\_\_\_\_\_ **Light / Moderate / Heavy**

Have you had a hysterectomy? **Yes/No** If yes, Reason for surgery? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How old were you when your periods began? \_\_\_\_\_\_\_\_\_ Do you still have your ovaries? **Yes/No**

How many days from the **start of one cycle** to the **start of another**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Last Pap smear**\_\_\_\_\_/\_\_\_\_/\_\_\_\_\_ **Last Mammogram**\_\_\_\_\_/\_\_\_\_/\_\_\_\_\_ **Last Colonoscopy**\_\_\_\_\_\_/\_\_\_\_/\_\_\_\_

How many sexual partners have you had in the past year? \_\_\_\_\_ What gender do you identify with? **\_\_\_\_\_\_\_\_\_\_\_**

Do you have sexual relations with men, women, or both? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you satisfied with your sex life? **Yes/No** If no, why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you experience dryness or pain with sexual activity? **Yes/No**

Do you use lubricants? **Yes/No** Any loss in sexual interest? **Yes/No**

Do you orgasm as easily and frequently as you desire? **Yes/No**

Are you trying to get pregnant? **Yes/No** If so, for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever taken “fertility” drugs? **Yes/No** Which ones? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check the method(s) of birth control that you are currently using:**

\_\_\_Birth Control pill/patch \_\_\_Condoms \_\_\_NuvaRing \_\_\_Diaphragm \_\_\_Vasectomy \_\_\_Nexplanon/Implanon

\_\_\_Tubal Ligation \_\_\_IUD \_\_ Spermicide \_\_\_Withdrawal \_\_\_Rhythm/NFP \_\_\_Abstinence \_\_\_None

**Surgical History:**

Surgery Hospital Date Reason

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have any drug allergies? Yes / No** Latex allergy? **Yes / No**

**Allergy Reaction**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Immunization History:** \_\_\_\_Up to date \_\_\_\_ Unsure \_\_\_\_ Need Immunizations

**Family History:** Please check the diseases below that affect your family members, and list their relation to you:

Breast Cancer Ovarian Cancer Colon Cancer

Uterine Cancer Uterine Fibroids Other Cancer (type)

Diabetes Heart disease Osteoporosis

High cholesterol Thyroid disease Hypertension

Birth defects Cognitive/Intellectual Disabilities Endometriosis

Blood clots/DVT Genetic disorders Other

What is your nationality? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social:**

Marital status\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Years in current relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Partner’s name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Partner’s occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Partner’s history: Hepatitis\_\_\_\_\_\_\_ Herpes\_\_\_\_\_\_\_ Any sexually transmitted diseases\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been emotionally, sexually or physically abused? **Yes/No**

If yes, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use tobacco/vape? **Yes/No** How many packs per day? \_\_\_\_\_ How many years? \_\_\_\_\_\_\_\_\_\_

Do you drink alcohol? **Yes/No** How many drinks per week? \_\_\_\_ For how many years? \_\_\_\_\_\_\_

Do you use recreational drugs, including marijuana products? **Yes/No** If yes, which drugs?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been addicted to drugs or alcohol? **Yes/No**

Do you drink caffeinated beverages? **Yes/No** How many per day? \_\_\_\_\_\_\_\_

What kind of exercise do you do? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list current medications:**

**Medication Dosage For how long**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Vitamins:** What vitamins or herbal supplements do you use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pregnancy History:** Number of pregnancies \_\_\_\_\_ Miscarriages \_\_\_\_\_ Abortions \_\_\_\_\_

**If you are currently pregnant, please complete the following information about your   
previous pregnancies (including any miscarriages or abortions).**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Year | Hospital | # Weeks  at delivery | # Hours  in Labor | Sex | Weight | Type of delivery | Complications | Baby’s  Name |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |

I understand that this is a confidential questionnaire and I have answered the above to the best of my knowledge.

Please print name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_