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PATIENT MEDICAL QUESTIONNAIRE

TODAY'S DATE: _____ DOB: _____

Name _____Age_____ Occupation_____

Name of your family physician?_____ Phone number to call with your test results? (_____)_____

May we leave a message on your answering machine? Y ( ) N ( ) To whom may we release information?_____

Main reason for your visit today?_____
Do you have other issues and/or concerns you would like addressed during your Annual Well Woman Visit? (**An additional Office Visit will be charged or you may schedule a separate Office Visit for a later date.)**

YES_____ NO_____

OBSTETRICAL HISTORY: List ALL pregnancies (including miscarriages, abortions, etc.)

	Year	Length of Pregnancy	Place of Delivery or Hospital	Vag Del or C/S	Complications	Birth Wt.	Sex
1.	_____	_____	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____	_____	_____

GYNECOLOGICAL HISTORY:

MENSTRUAL PERIODS:
First day of last period _____
Age when you started _____
How many days do you flow?_____
Menstrual cycle length_____
(Length of time from the first day of your period to the start of your next period)

PAP SMEAR RESULTS:
Date of last Pap smear _____ Was your last Pap smear normal? Yes No
Have you ever had an abnormal Pap smear? Yes No
Date _____Results_____
Action taken: Include repeat Pap smear, colposcopy, biopsy, cauterization.
Date:_____Results: _____

SEXUALITY:
Age of 1st intercourse?___
Total number of sexual partners?_____
Number of sexual partners in past year? ____If any?
Male, Female or both?_____

BIRTH CONTROL:
Current Method_____ Vasectomy_____
Previous Method_____
Problems_____

MAMMOGRAM:
When was the last one?_____
Do you perform self breast exams?_____

Date of Last Colonoscopy_____

Check if you have had any of the following:

	Current Problem	Past Problem	Never
Painful periods	_____	_____	_____
Bleeding between periods	_____	_____	_____
Irregular Periods	_____	_____	_____
Excessive Uterine Bleeding	_____	_____	_____
Infection of Uterus,Tubes, or Ovaries (PID)	_____	_____	_____
DES Daughter	_____	_____	_____
Chlamydia	_____	_____	_____
Gonorrhea	_____	_____	_____
Syphillis	_____	_____	_____
Herpes	_____	_____	_____
HIV/AIDS	_____	_____	_____
Venereal Warts	_____	_____	_____
Vaginal Trichomoniasis	_____	_____	_____
Vaginal Bacterial Infection	_____	_____	_____
Vaginal Yeast Infection	_____	_____	_____
Breast Lumps or Cysts	_____	_____	_____
Involuntary urine loss	_____	_____	_____
Bladder Infection-Frequent	_____	_____	_____
Kidney Problems	_____	_____	_____
Feeling that pelvic organs are falling out?	_____	_____	_____
Painful intercourse	_____	_____	_____
Sexual or marital problems	_____	_____	_____
Domestic Violence	_____	_____	_____

Exercise_____ Diet_____

Date of Last Bone Density_____

Existing medical problems:_____

Have you fallen in the past 6 months?_____

Medications:		Allergies to Medications	Reactions
1._____	4._____	1._____	_____
2._____	5._____	2._____	_____
3._____	6._____	3._____	_____

Any vitamins and/or herbal therapies?_____

PAST MEDICAL HISTORY:

Previous surgery (including D&C, tonsils, etc.)

Year	Surgery	Hospital
_____	_____	_____
_____	_____	_____

Previous hospitalizations other than surgery:

Year	Surgery	Hospital
_____	_____	_____
_____	_____	_____

REVIEW OF SYSTEMS: (Have you ever had any of the following problems?)

Cardiovascular		**Pulmonary**		**Gastrointestinal**		**Other**	
Congenital Heart Defect	Y N	Asthma	Y N	Ulcers	Y N	Arthritis	Y N
Coronary Artery Disease	Y N	Pneumonia	Y N	Bloody Stool/Vomitus	Y N	Lupus	Y N
Heart Murmurs	Y N	**Endocrine Problems**		Bowel Habit Changes	Y N	Cancer	Y N
Blood Clots (legs or lungs)	Y N	Thyroid Problems	Y N	Irritable Bowel Syndrome	Y N	Type_____	
High Blood Pressure	Y N	Diabetes	Y N	Colitis/Chron's Disease	Y N	Psychiatric Care	Y N
Chest Pains	Y N	**Urologic**		**Neurological**		Drug or Alcohol Prob	Y N
Anemia	Y N	Kidney Infection	Y N	Frequent Headache	Y N	Bone Problems	Y N
Blood Transfusions	Y N	Kidney Stones	Y N	Fainting Spells	Y N	Recent Weight Change	Y N
When?_____		Bladder Infection	Y N	Seizures	Y N	Depression	Y N
				Migraines	Y N	Bipolar Disorder	Y N

FAMILY HISTORY: Grandparents, parents, brothers, sisters, aunts, children have/had:

	YES	NO	Relationship		YES	NO	Relationship
Cardiac Disease	( )	( )	_____	Cancer Breast	( )	( )	_____
High Blood Pressure	( )	( )	_____	Cancer Colon	( )	( )	_____
Diabetes	( )	( )	_____	Cancer Ovarian	( )	( )	_____
Genetic Disorders	( )	( )	_____	Cancer Uterine	( )	( )	_____
Psychiatric Disorders	( )	( )	_____	Osteoporosis	( )	( )	_____
Clotting Problems	( )	( )	_____	Other cancers	( )	( )	_____

IMMUNIZATION HISTORY: Date of Last TDAP?_____ Have you had: Pneumonia Vaccine_____ Flu Shot_____
If not, why:_____

SOCIAL HISTORY:

Single ( ) Married ( ) Separated ( ) Widowed ( ) Divorced ( )

Do you Smoke? Yes ( ) No ( ) How many packs per day? _____ Have you ever smoked? Yes ( ) No ( )

Do you drink alcohol? Yes ( ) No ( ) How often?_____ Recreational drug use? Yes ( ) No ( )

Do you have a living will or health care power or attorney? Yes ( ) No ( )

Religious Affiliation? Yes ( ) No ( ) _____

I realize that if tests are taken for sexually transmitted diseases, reporting of certain positive results to public health agencies is required by law.

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any change in my medical status. I also understand that if follow-up is needed, I will assume responsibility for such follow-up.

Patient Signature _____Date_____

Reviewed by_____Date_____