# PATIENT HEALTH QUESTIONNAIRE

Name ____________________________________________ Age _________ Date ________________

Reason for your visit today: ________________________________________________________________

_____________________________________________________________________________________

## MEDICATIONS/ ALLERGIES

Current medications (prescription and over-the-counter) ________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

Vitamin, herbal, or calcium supplements _________________________________________________

Medication Allergies (with reaction) ____________________________________________________

Any known allergy to LATEX? …………………………………………………………… Yes No

## REPRODUCTIVE HISTORY

First day of last menstrual period __________________ Age at first menstrual period _______________

How often do you get your period? Every __________ days ………………….. Regular Irregular

How many pads/tampons do you use on your heaviest day? _____________________________________

Any spotting/pain between periods? ………………………………………………… Yes No

Do you have pain with periods? ……………………………………………………… Yes No

Do you have pain with intercourse? …………………………………………………… Yes No

Are you in a monogamous relationship? …………………………………………….. Yes No

Is your primary sexual partner a? ………………………...…………………… Female Male

Current contraceptive method ____________________________________________________

Have you ever had a sexually transmitted disease? …………………………………… Yes No

If yes, please explain: _________________________________________________________

Date of last Pap smear _________________________________________________________

Have you ever had an abnormal Pap smear/ date? ___________________________________________

Do you do self breast exams? ______________________ Last mammogram? ______________________

Have you ever had a bone scan/ when/ findings? _____________________________________________

Do you find it hard to hold your urine? ................................................ Yes No

Do you ever leak urine with coughing, sneezing, or exercise? ........................ Yes No

How many times do you urinate during the night? __________

Do you ever leak stool inappropriately? ............................................. Yes No

Any history of infertility? ............................................................ Yes No

**OBSTETRICAL HISTORY – Please list each pregnancy, its outcome and any complications**

| Year | Vaginal/Cesarean Miscarriage/Term. | Length of Labor | Weeks at Delivery | Birth Weight | Sex | Complications |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

**MEDICAL HISTORY – Please indicate if you have ever been diagnosed with one of the following:**

____ Anemia
____ Arthritis
____ Asthma
____ Bleeding problem
____ Breast cancer
____ Diabetes
____ DVT/ blood clots
____ Eating disorder
____ Heart disease
____ High blood pressure
____ High cholesterol
____ Kidney disease
____ Liver disease
____ Migraines
____ Osteoporosis
____ Seasonal allergies
____ Stroke
____ Thyroid disease
____ Other: ______________________________________________

Date of last cholesterol check ______________ Was it normal? ____________________

**SURGICAL HISTORY/ HOSPITALIZATIONS/ BLOOD TRANSFUSIONS**

| Year | Surgery | Year | Surgery |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**FAMILY HISTORY – Indicate if an immediate family member has the following (parents, grandparents, siblings, children)**

| | | |
|---|---|---|
| _______ Breast Cancer | _______ Heart Disease | _______ Osteoporosis |
| _______ Colon Cancer | _______ High Blood Pressure | _______ Ovarian Cancer |
| _______ Diabetes | _______ High Cholesterol | _______ Stroke/ DVT |

**PERSONAL HISTORY**

What major stressors are currently affecting you?_______________________________________________

Are you coping well with them? ……………………………………………………………. Yes No

Do you often feel sad or miserable? ………………………………………………………... Yes No

Do you often have any difficulty sleeping? ……………………………………………. Yes No

Are you having trouble enjoying/ participating in daily activities? ……………………… Yes No

Do you ever think of harming yourself or others? ……………………………………….. Yes No

Do you think you have a weight problem? …………………………………………………. Yes No

Have you ever tried binging/starving/purging for weight loss? …………………………. Yes No

Have you ever been hit, kicked, or punched by an intimate partner? ……………………. Yes No

Are you currently? ………………………………………………………………………….. Yes No

Have you ever been forced to have sex by an intimate partner? ………………………… Yes No

Do you smoke/ how much/day? _______________ Have you tried to quit? _______________________

How much do you drink per week? __________________________________________

Any history of recreational drug use (cocaine, marijuana, heroin)? ___________________________

Do you exercise regularly/ activity/ how often per week? ____________________________________