

PATIENT QUESTIONNAIRE

OFFICE USE

Date: _____

Age: ____ G ____ P ____

Name: _____

S M Sep Div W

Preferred Name: _____

LMP: _____

Birth Date: _____

Contra: _____

Birth Place: _____

PRIMARY PROBLEM OR SYMPTOMS: (reason for today's visit) _____

How long has this gone on? 1 day ____ 1 week ____ 1 month ____ 1 year ____ 1+ years ____

OBSTETRICAL HISTORY:

Pregnancies: List in sequence from first to most recent, including miscarriages and abortions

<u>DATE</u>	<u>PLACE (city or hosp.)</u>	<u>SEX</u>	<u>WEIGHT</u>	<u>COMPLICATIONS</u>
1) _____	_____	_____	_____	_____
2) _____	_____	_____	_____	_____
3) _____	_____	_____	_____	_____
4) _____	_____	_____	_____	_____
5) _____	_____	_____	_____	_____

(use back of this page if more)

MEDICAL HISTORY:

List any illnesses, current or past, under the care of a physician (i.e, diabetes, etc.)

<u>Year</u>	<u>Diagnosis</u>	<u>Medications</u>	<u>Year</u>	<u>Diagnosis</u>	<u>Medications</u>
1) _____	_____	_____	4) _____	_____	_____
2) _____	_____	_____	5) _____	_____	_____
3) _____	_____	_____	6) _____	_____	_____

Have you ever had any of the following? (circle if yes)

- | | | | |
|-----------|-----------------|----------------------|--|
| diabetes | heart murmur | high blood pressure | seizures |
| hepatitis | thyroid problem | mononucleosis (mono) | transfusion of blood or blood products |
| asthma | tuberculosis | migraine headaches | |

SURGICAL HISTORY: (list all operations giving date and city)

_____	_____
_____	_____
_____	_____

Have you ever had any hospitalizations other than above? Yes ____ No ____
(If yes, list on back of page)

Have you ever had any major injuries not listed above? Yes ____ No ____
(If yes, list on back of page)

ALLERGIES AND MEDICATIONS:

Are you allergic to any medications? ____ If yes, what? _____

What type of reaction? _____

List all medications you are presently taking, including vitamins/minerals: _____

GYNECOLOGICAL HISTORY:

Yes

No

Menses:

Last menstrual period began _____
 Age when menses began _____
 How many days do you bleed? _____
 How many days between first days of each period? _____
 Do you clot with your menses? _____
 Are your cycles irregular? _____
 Date of last Pap smear _____
 Have you ever had an abnormal Pap smear? _____
 If yeas, when and what therapy did you receive? _____

Pain:

Do you have pain with your menses? _____
 Do you have pain with ovulation? _____
 Are you having sexual relations? _____
 Are you having intercourse? _____
 Do you have pain with intercourse? _____
 Do you get satisfaction from your sexual relations? _____

Bleeding:

Do you bleed between periods? _____
 Do you bleed after intercourse? _____
 Do you bleed from your rectum? _____
 Have you had any recent change in your cycle? _____

Infection:

Do you have a vaginal discharge? _____
 Do you have any itching? _____
 Do you have any burning? _____
 Have you ever had a pelvic infection (PID)? _____
 Have you ever had any of the following: (Check, if yes)
 Gonorrhea ____ Chlamydia ____ Herpes ____
 Syphilis ____ Genital warts ____
 Has your partner had any of the above? (If yes, list on back) _____

Contraception:

Are you using a method of birth control?
 If so, which one(s)? (check below)
 Condoms ____ Rhythm ____ Foam or Jelly alone ____ IUD ____
 Sponge ____ Withdrawal ____ Diaphragm or cervical cap ____
 Pill ____ Name of Pill _____ How long? _____
 Sterilization ____ tubal ligation/vasectomy (circle one)

Are you dissatisfied with your current method of birth control? _____
 Have you ever used the Pill? _____
 Did you have any problems? (explain on the back) _____
 Have you ever used an IUD? Type _____
 Did you ever have any problems? (explain on back) _____
 Do you desire to have children in the future? _____
 Have you had any of the following? (explain on back)
 Endometriosis? _____
 Fibroids? _____
 Ovarian cysts or tumors? _____

Breasts:

Do you have discharge from your breasts? _____

Do you have any lump(s) in your breasts? _____

Do you check your breasts every month? _____

Have you ever had a mammogram? When _____

Have you ever had a breast biopsy? _____

Do you notice unusual hair growth on your breasts, face, or elsewhere? _____

Menopause:

Are you bothered by hot flashes? _____

Do you have trouble sleeping? _____

Do you notice vaginal dryness? _____

Do you have night sweats? _____

Do you feel anxious? _____

Have you taken estrogens? _____

Have you lost weight? _____

Other problems? (list hormones that you are taking) _____

Urinary:

How often do you urinate? _____

Do you have a strong urge to urinate? _____

Do you have to hurry to the toilet? _____

Does the sight or sound or feel of running water cause you to lose urine? _____

Are you ever unaware that you are losing your urine? _____

Do you lose urine when you cough, laugh or sneeze? _____

Large or small amounts? _____

Do you ever have to wear a pad? _____

Do you have a feeling of pressure or bearing down? _____

Do you have a bulging from your vagina? _____

FAMILY HISTORY:

Please list your natural parents' ages, whether they are still alive or deceased, and any major illnesses they have or had. Illnesses

Mother: Age _____ Alive _____ Dec. _____ _____

Father: Age _____ Alive _____ Dec. _____ _____

Siblings: How many? _____ Illnesses _____

Has anyone in your family had any of the following? (include blood relatives, i.e., parents, grandparents, sisters, brothers, uncles, aunts, and children)

	<u>Yes</u>	<u>No</u>	
High blood pressure	_____	_____	Who? _____
Heart attack	_____	_____	Who? _____
Stroke	_____	_____	Who? _____
Diabetes	_____	_____	Who? _____
Breast cancer	_____	_____	Who? _____
Colon cancer	_____	_____	Who? _____
Other cancers	_____	_____	Who? _____
Retardation/birth defects	_____	_____	Who? _____
Endometriosis	_____	_____	Who? _____
Alcoholism	_____	_____	Who? _____
Osteoporosis	_____	_____	Who? _____

FAMILY HISTORY CONTINUED:

Any other serious illnesses? If so, what and what?

Did you mother receive Stilbestrol (D.E.S.) while pregnant with you? _____

YES

NO

SOCIAL HISTORY:

Do you have a regular exercise program? _____

Have you ever smoked cigarettes? _____

Do you smoke now? _____

If so, how much daily? _____

Do you use other recreational drugs? _____

Do you drink alcohol? _____

If so, how much daily? _____

Are you currently having problems with your marriage or partner? _____

Do you wish to discuss any of the above answers? _____

Have you ever lived out of the United States? _____

Where? _____ When? _____

QUESTIONS OR COMMENTS?

Thank you for filling out this lengthy, detailed questionnaire. It helps us a great deal.