

HEALTH QUESTIONNAIRE

Name: _____ Today's Date: _____
Age: _____ Date of Birth: _____
Occupation: _____ Present Menstrual Cycle: Regular Irregular
First day of last normal menstrual period: _____ Date of last PAP smear: _____
Number of pregnancies: _____ Number of living children: _____
1. Reason for your visit today (circle only one): Yearly exam Consultation Problem
If Consultation or Problem, please explain: _____
2. When was your last physical exam? _____ Do you have a Primary Care Physician? Yes No
Physician's Name: _____
3. Please list ALL medications you currently take: _____
4. Do you have any allergies to any medications? _____
5. Are you sexually active? Yes No If Yes, with Male Female
If Yes, are you: Monogamous (one partner) for _____ months/years
Not monogamous (multiple partners)
If Yes, is anything used to prevent pregnancy:
Pills Condoms Diaphragm Depo-Provera Shots Withdrawal Method IUD
Vasectomy Tubal Ligation (tubes tied) Essure Implanon Other: _____

DIRECTIONS: CIRCLE Y (YES) N (NO)

6. Y N Does anyone in your family have a history of (please check all that apply):
Breast Cancer Ovarian Cancer Heart Disease Hypertension Colon Cancer
Uterus Cancer Diabetes Osteoporosis Blood Clots (legs, lungs, etc.)
7. Y N Any history of sexually transmitted disease(s)? Herpes HIV Chlamydia
Gonorrhea Trichomoniasis HPV Syphilis Other: _____
8. Y N Any history of an abnormal PAP with precancer (dysplasia) or cancer?
If Yes, when: Treatment: _____
9. Y N Do you use tobacco products? If yes, pack(s): _____ per day
10. Y N Do you use alcohol products? If yes, drink(s): _____ per day
11. Y N Do you use illegal/recreational drugs now or have you used any in the past?
If yes, PLEASE LIST: _____
12. Y N Have you ever had any surgery? If yes, PLEASE LIST: _____

13. Y N Any chronic (long-term) medical problems? If yes, PLEASE LIST: _____

14. Y N Do you have any significant, persistent change in your bowel movements or blood in your stool?
15. Y N Do you want information on domestic violence?
16. Y N If you are 26 or younger, have you received the Gardasil vaccine?
If yes, did you receive all three doses? When was your last dose? _____
If no, are you interested in receiving the vaccine? _____
17. Y N If you are over 40, when was your last mammogram? _____
18. Y N If you are 50 or older, have you ever had a sigmoidoscopy/colonoscopy? If yes, when? _____
19. Y N If you are 50 or older, has your thyroid ever been checked? If yes, when? _____
20. Y N If postmenopausal, have you ever had a bone density test? If yes, when? _____

I understand the above information is necessary to provide me with medical care in a safe and efficient manner. I have answered all questions to the best of my knowledge. I will notify the doctor of any change in my health or medications.

Patient Signature _____ Date: _____

Physician/NP Signature _____ Date: _____

Best telephone number to reach me is: _____