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: 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
   Vasectomy Tubal Ligation (tubes tied) Other: _____

DIRECTIONS: CIRCLE Y (YES) N (NO)

6. Y N Do you exercise for more than 30 minutes, 3-5 times weekly?
7. Y N Do you consistently eat foods that are fried or high in fat?
   Date of your last cholesterol screening: _____
8. 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.)
9. Y N Any history of a sexually transmitted disease(s)? Herpes Chlamydia Gonorrhea Trichomoniasis
   HPV Syphilis Other: _____
10. Y N Any history of an abnormal PAP with precancer (dysplasia) or cancer?
    If yes, when: _____ Treatment: _____
11. Y N Do you use tobacco products? If yes, pack(s): _____ per day
12. Y N Do you use alcohol products? If yes, drink(s): _____ per day
13. Y N Do you use illegal/recreational drugs now or have you used any in the past?
    If yes, PLEASE LIST: _____
14. Have you ever had any surgery? If yes, PLEASE LIST: _____
    _____
15. Y N Any chronic (long-term) medical problems? If yes, PLEASE LIST: _____
    _____
16. Y N Do you have any significant, persistent change in your bowel movements or blood in your stool?
17. Y N Do you want information on domestic violence?
18. Y N Do you perform monthly breast self exams monthly?
19. Y N Do you take a calcium supplement?
20. Y N If you are over 40, have you had a baseline mammogram? If yes, date of exam: _____
21. Y N If you are 50 or older, have you ever had a sigmoidoscopy/colonoscopy? If yes, when? _____
22. Y N If you are 60 or older, has your thyroid ever been checked? If yes, when? _____
23. 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: _____