GYNECOLOGY & OBSTETRICS OF DEKALB

Your Name: _____ Today's Date: _____

Name of Pharmacy: _____ Pharmacy Phone: _____

Pharmacy Address: _____

HEALTH QUESTIONNAIRE

Date of Birth: _____ Age: _____ 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: _____

- Reason for your visit today: _____
- Do you have a Primary Care Physician? ❑ Yes ❑ No
  Physician's Name: _____
- When was your last physical exam? _____
- Please list ALL medications you currently take: _____
  _____
  _____
- Do you have any allergies to any medications? ❑ Yes ❑ No
  Please list: _____
- 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: CHECK Y (YES) N (NO)

1) Does anyone in your family have a history of (please check all that apply): ❑ Yes ❑ No
   ❑ Breast Cancer ❑ Ovarian Cancer ❑ Heart Disease ❑ Hypertension
   ❑ Colon Cancer ❑ Uterine Cancer ❑ Diabetes ❑ Osteoporosis
   ❑ Blood Clots (legs, lungs, etc.)
2) Do you have a history of sexually transmitted disease(s)? ❑ Yes ❑ No
   ❑ Herpes ❑ HIV ❑ Chlamydia ❑ Gonorrhea
   ❑ Trichomoniasis ❑ HPV ❑ Syphilis
   ❑ Other: _____

3) Do you have a history of an abnormal PAP with precancer (dysplasia) or cancer? ❑ Yes ❑ No
   If Yes, when: _____ Treatment: _____
4) Do you use tobacco products? ❑ Yes ❑ No
   If yes, pack(s): per day _____
5) Do you use alcohol products? ❑ Yes ❑ No
   If yes, drink(s): per day _____
6) Do you use illegal/recreational drugs now or have you used any in the past? ❑ Yes ❑ No
   If yes, PLEASE LIST: _____
7) Have you ever had any surgery? ❑ Yes ❑ No
   If yes, PLEASE LIST: _____
8) Do you have any chronic (long-term) medical problems? ❑ Yes ❑ No
   If yes, PLEASE LIST: _____
9) Do you have any significant, persistent change in your bowel movements or blood in your stool? ❑ Yes ❑ No
10) Do you want information on domestic violence? ❑ Yes ❑ No
11) If you are 26 or younger, have your received the Gardasil vaccine? ❑ Yes ❑ No
   If yes, did you receive all three doses? ❑ Yes ❑ No
   When was your last dose? _____
   If no, are you interested in receiving the vaccine? ❑ Yes ❑ No
12) If you are over 40, when was your last mammogram? _____
13) If you are 45 or older, have you ever had a sigmoidoscopy/colonoscopy? ❑ Yes ❑ No
   If yes, when? _____
14) If you are 50 or older, has your thyroid ever been checked? ❑ Yes ❑ No
   If yes, when? _____
15) If you are postmenopausal, have you ever had a bone density test? ❑ Yes ❑ No
   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 Name: _____ Date: _____
(please print)

Patient Signature: _____

Physician/NP Signature: _____

Clinical staff only

Height _____ Weight _____ B/P_____ UA _____ Hgb_____