



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 you 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 50 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 _____