PATIENT QUESTIONNAIRE

Please fill out completely, mark N/A if something doesn't apply. Thank you.

Date: ___________________________

Name: ____ Date of Birth: ____________ Age: _____________

Who is your primary care physician? ____

How did you hear about us? ____

Were you referred by a doctor? _________ If so, who? ____

Do you have a religious preference? ____

Pharmacy name and phone number: ____

Pharmacy address: ____

Main reason for today's visit: Annual/ Other (please circle one)

____

Have you ever had a mammogram? Yes / No

If so, when was the most recent? ____

Have you had a bone density scan? Yes/ No

If yes, when was the most recent? ____

Have you had your current flu shot? Yes / No

Have you ever had a colonoscopy? Yes/ No

If yes, when was the most recent? ____

Medications:

Do you take any medications, including over the counter or herbal/vitamins? (Please include all known dosages.)

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____

PATIENT QUESTIONNAIRE

Past Medical History:

Do you or did you have any of the following medical problems?

- Diabetes YES/ NO
- Hypertension YES/ NO
- High Cholesterol YES/NO
- Bone loss YES/NO
- Autoimmune disease YES/ NO
- Seizure disorder YES/ NO
- Hepatitis YES/ NO
- Migraines YES/ NO
- Kidney disease or frequent urinary tract infections YES/ NO
- Thyroid dysfunction YES/ NO
- Asthma YES/ NO
- Heart disease YES/ NO
- History of blood clots in your lungs or legs YES/ NO
- Psychiatric disorder YES/ NO
- AIDS YES/ NO
- Involved in a major accident YES/ NO
- Cancer YES/ NO
- Sickle cell disease or trait YES/ NO
- Anemia YES/ NO
- Bleeding disorder YES/ NO
- Other (please list)__________________

Are you allergic to any medications? Yes / No

If so, what and what reactions? ____

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Gynecologic History:

If you HAVE NOT gone through menopause, answer this section:

When was your last period? ____

How often do your periods come? ____

How many days does your period last? ____

Is your flow light, moderate or heavy? ____

Do you have pain with your periods? ____

If you HAVE gone through menopause, answer this section:

When did you stop having periods? ____

Have you ever been evaluated for bleeding after menopause? Yes / No

Have you ever taken hormone replacement therapy? Yes / No

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Have you ever had an abnormal Pap smear? Yes / No

If yes, what type of treatment did you receive? ____

When was your last Pap smear? ____

Have you ever had the following:

Gonorrhea? Yes / No   Chlamydia? Yes / No   Genital herpes? Yes / No

Genital warts? Yes / No   Syphilis? Yes / No   Pelvic inflammatory disease? Yes / No

What are you using for birth control? ____

Have you used anything else in the past? Yes / No

If so, what? ____

How old were you when you started your period? ____

Have you ever been treated for infertility? Yes / No

Have you ever been diagnosed or treated for:

Ovarian cysts? Yes / No

Fibroids? Yes / No

Endometriosis? Yes / No

Have you had all 3 Gardasil (cervical cancer) vaccinations? Yes / No

What is your sexual orientation? Heterosexual   Bisexual   Homosexual

Past Pregnancy History:

Date	Weeks at Delivery	Weight	Sex	Route of Delivery	Outcome or Complications

Have you ever been hospitalized overnight? Yes / No

What for?____

____

____

Have you ever received a blood transfusion? Yes / No

Have you ever had surgery? Yes / No

Please list all surgeries and/or biopsies: ____

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____

Family History:

What is your race or ethnic background?____

Ashkenazi Jewish descent? ____

Does anyone in your family have any of the following? Please indicate Maternal or Paternal and relationship to you. **(IE: Mother, Father, Maternal grandparents, Paternal Aunt, sister, brother, etc….)**

History of:	Yes-Close Family/Who?	No	History of:	Yes-Close Family/Who?	No
Diabetes			Down syndrome		
Heart Disease			Congenital heart defects		
Hypertension			Neural tube defects		
Kidney Disease/UTI			Hydrocephalus		
Hepatitis/Liver Disease			Muscular Dystrophy		
Pulmonary (TB, Asthma)			Mental Retardation		
Neurologic/Epilepsy			Cystic Fibrosis		
Autoimmune Disorder			Osteoporosis		
Vascular/Thromboembolic			Cleft palate or lip		
Sickle Cell disease/trait			Infertility/DES		
Thalassemia			Deafness/Blindness		
Anemia			Breast Cancer		
Thyroid/Dysfunction			Ovarian Cancer		
Depression/Psychiatric Disorder			Uterine Cancer		
Trauma/Violence			Colon cancer		
Stroke/Heart attack			Other cancers		
Hemophilia			Other		

PATIENT QUESTIONNAIRE

Social History:

Do you smoke? Yes / No If yes, how much? ___________________________________

Do you drink alcohol? Yes / No If yes, how much per week? ___________________________

Do you use street drugs? Yes / No If yes, what? _______________________________________

Are you: Single? Married? Divorced? Widowed? Long-term relationship?

Are you currently employed? Yes / No If yes, what do you do? ______________________________

Have you ever been physically or sexually abused? Yes / No

Are you safe at home? Yes / No

Do you exercise regularly? Yes/ No

Review of Systems:

Do you have any of the following?

- Weight loss YES/ NO
- Weight gain YES/ NO
- Fever YES/ NO
- Fatigue YES/ NO
- Vision changes YES/ NO
- Double vision YES/ NO
- Hearing problems YES/ NO
- Sore throat YES/ NO
- Chest pain/pressure YES/ NO
- Difficult/painful breathing YES/ NO
- Swelling of legs YES/ NO
- Shortness of breath YES/ NO
- Chronic cough YES/ NO
- Bloody stool YES/ NO
- Nausea/vomiting YES/ NO
- Frequent diarrhea YES/ NO
- Constipation YES/ NO
- Blood in urine YES/ NO
- Painful urination YES/ NO
- Muscle/joint pain YES/ NO
- Rash YES/ NO
- Trouble with walking YES/ NO
- Seizures YES/ NO
- Headaches YES/ NO
- Depression/crying spells YES/ NO

Is there any other information you would like to share that is not covered above? Please feel free to comment on what brings you here today. ____

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OFFICE USE ONLY Ht______Wt______BP________Pulse______POX______Temp_______