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)

_____

Medications, Vitamins & Herbals:

Please list all of your medications (prescription and non-prescription), vitamins, herbal, & homeopathic remedies.

MEDICATION	DOSE OF EACH PILL (in mg, grams, units, etc.)	NUMBER OF PILLS YOU TAKE AND WHEN YOU TAKE THEM

Medication Allergies: ☐ None ☐ Penicillin ☐ Sulfa ☐ Other:_____

What kind of allergic reaction:_____

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 ☐

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- 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)_____

Gynecologic History:

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? _____

Have you had any flu like symptoms in the last 7 days? Yes/No

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

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: Total # of pregnancies _____

Deliveries:

Date	Weeks at Delivery	Baby 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 and dates: _____

_____

_____

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, Grandparents, Aunt, Sister, Brother, etc.…)**

History of:	Yes- Relationship to you?	Alive or Deceased (A/D) & Age	History of:	Yes- Relationship to you?	Alive or Deceased (A/D) & Age
Diabetes			Down syndrome		
Heart Disease			Congenital heart defects		
Hypertension			Neural tube defects		
Kidney Disease/UTI			Hydrocephalus		
Hepatitis or Liver Disease			Muscular Dystrophy		
Pulmonary (TB, Asthma, etc.)			Mental Retardation		
Neurologic or Epilepsy			Cystic Fibrosis		
Autoimmune Disorder			Osteoporosis		
Vascular or Thromboembolic			Cleft palate or lip		
Sickle Cell disease or trait			Infertility or DES		
Thalassemia			Deafness or Blindness		
Anemia			Hemophilia		
Thyroid or Dysfunction			Breast Cancer		
Depression or Psychiatric Disorder			Ovarian Cancer		
Trauma or Violence			Uterine Cancer		
Heart Disease			Colon Cancer		
Stroke or Heart attack			Other cancers		
High Cholesterol			Other		

Social History:

Yes / No Did you ***used to*** drink alcohol: How many occasions per week? _____ When you did drink, how may drinks did you usually drink in one day? _____ What would be the most that you would drink in one day? _____ When did you quit? _____

Yes / No ***Currently*** drink alcohol: How many occasions per week? _____ When you do drink, how many drinks do you usually drink in one day? _____ What would be the most that you would drink in one day? _____

Yes / No ***Used to*** smoke: How many packs per day? _____ How many yrs. did you smoke? _____ When did you quit? _____

Yes / No ***Currently*** smoke: How many packs per day? _____ How many yrs. have you smoked? _____

Yes / No Do you exercise? _____ What kind? _____

Marital Status: ☐Married ☐Divorced ☐Single ☐Widow ☐Long-term Relationship

Who lives with you? _____

Yes / No Do you or have you ever injected, taken or used recreational drugs? _____ What? _____What years? _____

Yes / No Are you currently employed? Occupation (list occupations):_____

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. _____

_____

_____

_____

OFFICE USE ONLY Ht_____Wt_____BP_____Pulse_____POX_____Temp_____

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