Patient Information Questionnaire

Name: ________________________ Phone #: ________________________ Today's Date: ________________________
DOB: __________ Age: __________ Pharmacy: ____
Number of Pregnancies: ______ Living: ______ Allergies: ____
____

Please Provide the Following Information

General Information

What is your primary reason for coming to see us today? Routine Exam Other: __________________________

Gynecologic and Obstetric Review:

If you have menstrual periods, when did your last menstrual period start? ____________________________________

Please Answer the Following Questions:

Have you had a Hysterectomy? Y N Have you been through menopause? Y N
Do you take hormone medication? Y N Have you had your ovaries removed? Y N
Are you presently sexually active? Y N
Do you plan a pregnancy in the near future? Y N
What are you using to prevent pregnancy? Nothing Condoms Diaphragm Pills Shots Implant IUD
Tubal Ligation Vasectomy Other: ____________________________
Do you want to continue your present method? Y N

OB/GYN Review of Systems:

Have you ever had gonorrhea, Chlamydia, Herpes, Genital warts, or other STD's? Y N
Do you want to be tested for sexually transmitted diseases today? Y N
Have you experienced problems with your breast or pelvic organs? Y N
Do you currently have any of the following:
Breast Problems, Sexual Problems, Difficulty with periods, Urine Leakage, Painful periods, Discharge,
Night Sweats, Abnormal body hair Other problems: ____

General Medical Review of Systems:

Since your last visit, have you been diagnosed with any of the following:

Lung Disease	Migraines	Cancer	Blood Pressure Issues	Kidney Disease
Stroke	Blood Clots in Veins or Lungs	Mental Illness	Heart Disease	Diabetes

Social and Family History:

What is your marital status? S M D W What is your job?________________________
Do you smoke, use tobacco, or vape? Y N How many per day: ____________
Do you drink alcohol? Y N How many drinks per day:_______
Do you use street drugs? Y N Last used:____________________
Within the last year, have **<u>You</u>** been hit, slapped, kicked, or otherwise physically hurt by anyone? Y N
Within the last year, has anyone forced **<u>You</u>** to have any sexual activities? Y N
Since your last visit, has anyone in **<u>Your</u>** family developed any of the following:
Colon Cancer, Breast Cancer, Ovarian Cancer, Heart Disease, Diabetes, Mental Illness, Bleeding Disorder, Tuberculosis

Are you up to date on your immunizations? Y N
Recommended: Flu Vaccine Date:________________ Where: ________________________________
T-Dap Date:________________ Where: ________________________________
Pneumonia vaccine: age 65
Shingles vaccine: age 60