

PATIENT HISTORY QUESTIONNAIRE

Date: _____

Patient Name: _____ DOB: _____

Marital Status: Single Married Long Term Relationship Divorced Widowed

PCP: _____ Referring Physician (if different than PCP): _____

Preferred phone number: _____ Occupation/Employer: _____

Reason for this visit: _____

Have you recently experienced any of the following?: (check any that apply)

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Weight changes | <input type="checkbox"/> Urinary frequency/pain | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Chest Pain/Palpitations |
| <input type="checkbox"/> Appetite changes | <input type="checkbox"/> Blood in urine or stool | <input type="checkbox"/> Bowel/urinary incontinence | <input type="checkbox"/> Breast discharge |
| <input type="checkbox"/> Hair loss | <input type="checkbox"/> Weakness/numbness | <input type="checkbox"/> Skin changes/rash | <input type="checkbox"/> Breast pain/mass |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Pelvic pain | <input type="checkbox"/> Depression/anxiety | <input type="checkbox"/> Hot flashes/Night sweats |
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Pain/bleeding with intercourse | <input type="checkbox"/> Other: _____ | |

CURRENT MEDICATIONS

Name: _____ Dose: _____ Frequency: _____

Name: _____ Dose: _____ Frequency: _____

Name: _____ Dose: _____ Frequency: _____

Name: _____ Dose: _____ Frequency: _____

PAST MEDICAL HISTORY (check any that apply or NONE)

- | | | | | |
|--|--|---------------------------------|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Infection/Stones | <input type="checkbox"/> Asthma | <input type="checkbox"/> Arthritis/Joint Pain | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Liver Disease/Hepatitis | <input type="checkbox"/> Heart Problem/Murmur | <input type="checkbox"/> HIV+ | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> MRSA/drug-resistant infection | <input type="checkbox"/> Cancer | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Seizures/Epilepsy | <input type="checkbox"/> Bowel problems/Ulcer | <input type="checkbox"/> Stroke | <input type="checkbox"/> Eye Problems | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Anemia/Blood Transfusion | | | |

DRUG ALLERGIES NO YES *If yes, please list drug name and reaction:*

GYNECOLOGIC HISTORY

Date of last pap smear: _____

Have you ever had an abnormal pap smear? YES NO *If yes, month/year of abnormal pap: _____*

Have you had treatment for an abnormal pap smear? YES NO

If yes, what type of treatment(s) have you had? (please include year)

Colposcopy _____ Cryotherapy _____ Laser _____ Cone Biopsy _____ LEEP _____

MENSTRUAL HISTORY (complete even if post-menopausal or no longer having periods)

Age at first period: _____ years First day of last period: _____ / _____ / _____

Your menstrual periods start every: _____ days Duration of bleeding: _____ days

Does bleeding or spotting occur: between periods? after intercourse?

Is pain associated with periods? YES NO OCCASIONALLY

If yes, is it: before menses? during menses? both?

For postmenopausal women: Menopause at age: _____ Any postmenopausal bleeding? YES NO

SEXUAL HISTORY

Do you have a sexual partner? NO YES (MALE FEMALE BOTH)

What birth control method(s) do you currently use? _____

HISTORY OF SEXUALLY TRANSMITTED DISEASE

Check any that apply: Syphilis HPV/Genital Warts Trichomonas Chlamydia HIV
 Gonorrhea Herpes Pelvic Inflammation Disease None

IMMUNIZATIONS (please list month/year)

Gardasil Series (HPV vaccine): _____

OTHER EXAMS (please include month and year of your last exam)

Mammogram: _____ Colonoscopy: _____ Bone Density Screening: _____

OBSTETRICAL HISTORY

	NUMBER		NUMBER		NUMBER		NUMBER
PREGNANCIES		ABORTIONS		MISCARRIAGES		LIVE CHILDREN	

BIRTHDATE OF CHILD	SEX OF CHILD	BIRTH WEIGHT OF CHILD	HOSPITAL OR LOCATION CHILD WAS BORN	WEEKS PREGNANT	TYPE OF DELIVERY (VAGINAL OR CESAREAN)

PAST SURGICAL HISTORY (List all surgeries and their year or NONE)

_____	Date: _____	_____	Date: _____
_____	Date: _____	_____	Date: _____
_____	Date: _____	_____	Date: _____
_____	Date: _____	_____	Date: _____

FAMILY HISTORY

Is there any family history of breast, colon, uterine, prostate or ovarian cancer? YES NO

Is there any family history of bleeding or clotting disorders or stroke? YES NO

FAMILY MEMBER	YEAR BORN	ALIVE/DECEASED?	MEDICAL HISTORY / AGE AT TIME OF DEATH
FATHER			
MOTHER			
BROTHER			
SISTER			
DAUGHTER			
SON			
SPOUSE			
MATERNAL GRANDMOTHER			
MATERNAL GRANDFATHER			
PATERNAL GRANDMOTHER			
PATERNAL GRANDFATHER			
OTHER			

Signature of Patient

Date

Signature of Provider

Date