

Patient History Questionnaire

Today's Date: ____/____/____

Are you currently pregnant? _____

Your Name _____ Date of Birth ____/____/____

Who referred you to this practice? _____

May we send a "Thank You" letter to that person? _____

When was your last gynecologic exam and PAP? _____ by Dr. _____

Who is your family or primary care doctor? _____

Please list any medical problems you have had in the past (i.e. heart disease, high blood pressure, asthma, etc)

Please list any surgeries, hospitalizations or serious accidents that you have had (including minor surgeries such as tonsils, wisdom teeth, appendix, etc)

Year Surgery

Please list any pregnancies you have had, including details as best as you can recall:

Year Sex #Weeks Baby Weight Type of Delivery Anesthesia Any problems with the pregnancy?

Have you ever had a miscarriage? _____ How many? _____

Have you ever had an abortion? _____ How many? _____

Have you ever had any of the following sexually transmitted diseases:

_____ Herpes _____ Human Papilloma Virus _____ Gonorrhea _____ Chlamydia
_____ Abnormal PAP _____ other _____ I will discuss at my appointment

Have you ever been sexually assaulted? _____

Age when you had your first period: _____ Frequency of menses: every _____ days, or IRREGULAR?

How many days of heavy bleeding? _____ Are your periods particularly painful? _____

Have you ever taken birth control pills? _____ What kind(s) _____

Are you sexually active? _____ How many current partners? _____

Are you involved in a lesbian or bisexual relationship? _____

Have you ever taken hormone replacement therapy for menopause? _____

Please list all medications, include doses:

Do you have any **ALLERGIES** to medications or foods? _____

Do you smoke? _____ How much? _____

Do you consume alcohol? _____ How much? _____

Do you engage in illegal drug use? _____

Are you: SINGLE MARRIED DIVORCED WIDOWED Spouse's name (if married) _____

What is your occupation? _____

Do you have any pets at home? _____

Have you been a victim of domestic violence? _____

Do you exercise? _____

What is your family background? (i.e. before they came to America) _____

What is the family background of your spouse? _____

Please list any cancers in your family:

Relative

Cancer Type

Please list any family history of medical diseases (such as diabetes, heart disease, hypertension, stroke, etc)

Relative

Medical Problem

Do you have any family history of birth defects, mental retardation, or babies that died at birth?

Does your spouse have any family history of birth defects, mental retardation or babies that died at birth?

Do you currently have any of the following symptoms:

- | | | |
|---|--|--|
| <input type="checkbox"/> Fever/Chills | <input type="checkbox"/> Diarrhea/Constipation | <input type="checkbox"/> Bloody Urine |
| <input type="checkbox"/> Weight gain/loss | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Painful Urination |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> other GI symptoms | <input type="checkbox"/> Urinary Incontinence |
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Breast pain/Breast lump |
| <input type="checkbox"/> Too hot/too cold | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Nipple discharge |
| <input type="checkbox"/> Menopause symptoms | <input type="checkbox"/> Bruise/Bleed easily | <input type="checkbox"/> Painful Intercourse |
| <input type="checkbox"/> muscle/joint pain | <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Vaginal discharge |
| <input type="checkbox"/> Bloating/gas | <input type="checkbox"/> Vision disturbances | <input type="checkbox"/> Vaginal or skin lesions |

Is there anything that we did not ask that you would like us to know, so that we can provide you with optimal gynecological care? _____

Contact Information

Today's Date: _____

Patient _____
Last Name First Name Middle Initial

Date of Birth _____

There may be occasions when we are unable to reach you to discuss your account information and / or your medical test results. Please indicate to us with whom we are allowed to discuss your information.

- You may discuss my account information and/or test results with **only myself**.
- I give permission for Premier doctors / staff to leave my test results on my **home answering machine** at telephone number: (_____)_____-_____.
- I give permission for Premier doctors / staff to leave my test results on my **cell phone voice mail** at telephone number: (_____)_____-_____.
- You may discuss my account information and/or test results with:
Name: _____
Relationship: _____
Telephone number: (_____)_____-_____

Please notify our office if you need to make changes to the above information.

Signature: _____ Date: _____