Established Patient History Questionnaire

Please answer all questions carefully prior to your visit. Answers are confidential.
Would you like a female chaperone? Yes ( ) No ( )

Name:________________________________ Today's Date: ___________Length of time since last general exam ____Months

Interval medical history: (Please circle either yes or no and explain if yes.) **Since your last full check up here, have you**

had any **illnesses** or **medical problems**? .YES / NO ____

tests or **x-rays**?........................YES / NO ____

surgeries or been **hospitalized** ?..YES /NO ____

new **information** regarding your family medical history?..YES / NO ____

vaccinations ?..............YES / NO ____

Please list your **ALLERGIES:**____

Please list your current **MEDICATIONS** (including dose and frequency:____

Interval GYN history: If you are in your reproductive years, please answer these questions about your reproductive history since you last visit here. Circle either yes or no, and explain if yes. The date of your last menstrual period __________________

Have your periods changed a lot?.............YES / NO ____

Have you had any pregnancies?................YES / NO ____

Have you changed your method of contraception?....YES / NO ____

YES / NO Are you regularly using contraception for sexual activity? (circle type) the pill / minipill / Depo-Provera tubal ligation / vasectomy / IUD / diaphragm / condom / Implanon / natural / cap / ring / patch

YES / NO Are you content with your sex life?

YES / NO How many sexual partners have you had in the past year?______ (circle) male female

Interval social history: (Please circle either yes or no and explain if yes.)

Has there been a change in your marital status since you last annual exam?....YES / NO ___________________________________

Has there been a change in your employment or occupation? ....YES / NO ___________________________________

Have there been significant changes in your lifestyle or daily routine?...........YES / NO ___________________________________

____

____

____

Alcohol: Do you currently drink alcohol? YES / NO Quit date:_________________________

Glasses per week usually consumed: wine_________ beer __________ cocktails _________ other__________

Have you ever felt that you should cut down on your drinking?.... YES / NO

Have your ever felt bad or guilty about your drinking?…..…........YES / NO

Smoking: Are you currently a smoker?……………..…......……...YES / NO Quit Date: ______________________________

Number of cigarettes per day smoked now: ____________ Other tobacco products used now? .....YES / NO ________________

Drugs: Recreational drugs used now?......YES / NO (circle): marijuana, cocaine, heroin, speed, hallucinogen, other___________

Emotional health: Have you been experiencing any emotional or mood problems? ....YES / NO

In the past year, have you had 2 weeks or more during which you felt sad, blue, or depressed, or when you lost all interest or pleasure in things that you usually cared about or enjoyed? ......YES / NO

Comment: ____

Alternative medicine Do you use any alternative or complementary forms of medicine? ....YES / NO

(circle) herbal remedies marijuana acupuncture homeopathy therapeutic touch chiropractic magnetic

other:____

____

____

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Name:______________________________________

Safety: Please answer the following:

YES / NO Do you wear seatbelts regularly?
YES / NO If you cycle, do you wear a bicycle/motorcycle helmet?
YES / NO Do you have smoke detectors in your home?
YES / NO If you smoke detector has batteries, have you checked/changed them in the last year?
YES / NO Are there adequate handrails for any stairs in your home?
YES / NO **If** you have young children, is the thermostat on your water heater turned down?
YES / NO **If** you own a gun,, is it secured away from children?
YES / NO Do you practice safe sex (monogamous relationship or condom use)?
Are you being hit or verbally abused at home or elsewhere? ....YES / NO
Are you now, or have you ever been forced to have sex without your consent? .....YES / NO

Health Maintenance

YES / NO Do you eat a balanced diet with plenty of fruits and vegetables and low in fat?
YES / NO Do you participate in regular physical activity or exercise? How often? _____times per week
What types of exercise?____
YES / NO Do you visit the dentist in the last year? How many times? ______
YES / NO Do you brush and floss daily?
YES / NO Has you cholesterol level ever been checked? Date: ________ Value: __________________
YES / NO Have you ever had a Pap smear? Date of most recent Pap smear:______________________
YES / NO Do you do monthly breast self exam?
YES / NO Have you ever had a mammogram? Date of most recent mammogram: _________________
YES / NO Did you have an eye exam in the past year with glaucoma screening?
YES / NO Do you check your skin periodically for unusual growths or changes in moles?
YES / NO Do you wear sunscreen when out of doors?
YES / NO If over 50 have you had a colonoscopy? Date? ________________
YES / NO If menopausal, have you had a bone density scan? Date? _____________

What are your health concerns or problems today?____
____
____

____pre-conception concerns
____cancer screening
____weight loss
____smoking cessation
____domestic violence
____home safety
____contraceptive options
____infertility
____menstrual difficulties
___sexual difficulties
___nutrition
___exercise programs
___alcohol or drug problems
___incontinence (urine or stool leakage)
___safe sex
___hormone replacement
___osteoporosis
___sexually transmissible diseases
___HIV testing
___PMS
___ vaginitis
___menopause
___vaccinations
___breast exam
___vitamin supplements
___abnormal moles
___marital counseling
___parenting issues
___stress reduction
___depression counseling
___cholesterol
___ fibroids
___ _________________
___ _________________

Patient signature: ________________________________ **Date:**_____________ ***THANK YOU!***

DOCTOR'S NOTES:

Clinician Signature__________________________________ ***Date:***______________________________

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