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Patient Name (printed): _____

Patient Signature: _____

Date: _____

Patient History Questionnaire

Reason for Visit: _____

Are you currently taking any medications? _____ Yes _____ No (If yes, please list)

Medications Dosage/Frequency/Amount

_____

_____

_____

_____

_____

Medical History:
Check any of the following that apply:

□ Migraine Headaches
□ High Blood Pressure
□ Heart Disease
□ High Cholesterol
□ Asthma
□ Anemia
□ Thyroid Problems
□ Diabetes
□ Hepatitis/Liver Disease
□ Depression/Anxiety
□ Autoimmune Disorder
□ Kidney Disease
□ Seizure Disorder
□ Cancer:
□ Other:

Allergies: _____ Yes _____ No If, yes, please specify below:
□ Seasonal
□ Latex
□ Drug: _____
_____

Surgical History:
Please check all surgeries that apply and specify year:

□ Breast
□ Ovary
□ Hysterectomy
□ Laparoscopy
□ D&C
□ C-Section
□ Ectopic Pregnancy
□ Laser/LEEP/Cryo of Cervix
□ Fibroid Tumors
□ Other: _____

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Family History:
Check all that apply:
(Please specify which family member and whether they are on the mother or father's side of the family)

□ Breast Cancer _____
□ Ovarian Cancer _____
□ Diabetes _____
□ High Blood Pressure _____
□ High Cholesterol _____
□ Heart Disease_____
□ Stroke _____
□ Other Cancer: _____
□ Other Cancer: _____
□ Other Cancer: _____

Social History:

Tobacco	□ Yes	□ No	How much? _____	Years? _____
Alcohol	□ Yes	□ No	How much? _____	How Often? _____
Illicit/Recreational Drugs	□ Yes	□ No	What kind? _____	How Often? _____
Exercise	□ Yes	□ No	How Often? _____	

Gyn History:

Abnormal Pap Smear	□ Yes/When? _____	□ No
Sexually Transmitted Disease	□ Yes/When? _____	□ No

Menstrual Cycle:
□ Regular # of days: _____
□ Irregular # of pads/tampons per day: _____

Are You Currently Sexually Active? _____ Yes _____ No
Do you a method of birth control? _____ Yes _____ No If yes, please check all that apply:

□ Pills _____	□ Diaphragm	□ Tubal Ligation	□ Condoms
□ IUD _____	□ Depo	□ Norplant	□ Implanon

OB History:
# of Pregnancies: _____
Full Term: _____# Pre-Term: _____# Miscarriages/Abortions: _____ # Live Births: _____

Preventative Care:
Primary Care Provider: _____
Last Mammogram: _____ Last Colonoscopy: _____
Last Pap: _____ Last Bone Density: _____