HEALTH QUESTIONNAIRE

Name: _____ Today's Date: _____
Age: _____ Date of Birth: _____
Occupation: _____ Present Menstrual Cycle: Regular Irregular
First day of last normal menstrual period: _____ Date of last PAP smear: _____
Number of pregnancies: _____ Number of living children: _____

1. Reason for your visit today (circle only one): Yearly exam Consultation Problem
   If Consultation or Problem, please explain: _____
2. When was your last physical exam? _____ Do you have a Primary Care Physician? Yes No
   Physician's Name: _____
3. Please list ALL medications you currently take: _____
   _____
4. Do you have any allergies to any medications? _____
5. Are you sexually active? Yes No If Yes, with Male Female
   If Yes, are you: Monogamous (one partner) for _____months/years
   Not monogamous (multiple partners)
   If Yes, is anything used to prevent pregnancy:
   Pills Condoms Diaphragm Depo-Provera Shots Withdrawal Method IUD
   Vasectomy Tubal Ligation (tubes tied) Essure Implanon Other:_____

DIRECTIONS: CIRCLE Y (YES) N (NO)

6. Y N Does anyone in your family have a history of (please check all that apply):
   Breast Cancer Ovarian Cancer Heart Disease Hypertension Colon Cancer
   Uterus Cancer Diabetes Osteoporosis Blood Clots (legs, lungs, etc.)
7. Y N Any history of sexually transmitted disease(s)? Herpes HIV Chlamydia
   Gonorrhea Trichomoniasis HPV Syphilis Other:_____
8. Y N Any history of an abnormal PAP with precancer (dysplasia) or cancer?
   If Yes, when: Treatment: _____
9. Y N Do you use tobacco products? If yes, pack(s): _____per day
10. Y N Do you use alcohol products? If yes, drink(s): _____per day
11. Y N Do you use illegal/recreational drugs now or have you used any in the past?
    If yes, PLEASE LIST: _____
12. Y N Have you ever had any surgery? If yes, PLEASE LIST: _____
    _____
13. Y N Any chronic (long-term) medical problems? If yes, PLEASE LIST: _____
    _____
14. Y N Do you have any significant, persistent change in your bowel movements or blood in your stool?
15. Y N Do you want information on domestic violence?
16. Y N If you are 26 or younger, have your received the Gardasil vaccine?
    If yes, did you receive all three doses? When was your last dose? _____
    If no, are you interested in receiving the vaccine? _____
17. Y N If you are over 40, when was your last mammogram? _____
18. Y N If you are 50 or older, have you ever had a sigmoidoscopy/colonoscopy? If yes, when? _____
19. Y N If you are 50 or older, has your thyroid ever been checked? If yes, when? _____
20. Y N If postmenopausal, have you ever had a bone density test? If yes, when? _____

I understand the above information is necessary to provide me with medical care in a safe and efficient manner. I have answered all questions to the best of my knowledge. I will notify the doctor of any change in my health or medications.

Signature _____ **Date:** _____
Physician/NP _____

******Clinical staff only******

Height_____ Weight _____ B/P_____ UA_____ Hgb_____