Florida Women's Health Center
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FLORIDA HOSPITAL
Memorial Medical Center
HealthCare Partners

HEALTH QUESTIONNAIRE

Name: ____ Date: __________________________________
Age: ______________________________________ Date of Birth: __________________________________
Occupation: ________________________________ Present Menstrual Cycle: ❒ Regular ❒ Irregular
First day of your last **normal** menstrual period: ______________ Date of last PAP smear: ___________________
Number of Pregnancies: _________________________ Number of living children: _________________________

1. When was your last physical exam? _____________ Primary Care Physician _____________________
2. ***Reason for visit: Yearly exam?*** ❒ ***Problem Visit?*** ❒ ***Yes*** ❒ ***No*** ***Both?*** ❒
   If problem, please state: ____
3. Current medications *(Please list)*: ____
   ____
4. Allergies to medications: ____
5. Are you sexually active? ❒ Yes ❒ No If yes, with ❒ Male ❒ Female
   If yes, ❒ monogamous (one partner) for ______________ months / years; ❒ **not** monogamous
   If yes, is anything used to prevent pregnancy? ❒Pills ❒Condoms ❒Diaphragm
   ❒Depo-Provera Shots ❒Withdrawal method ❒Vasectomy ❒Tubal ligation (tubes tied)
   Other: ____

*Directions: Circle **Y** (Yes) **N** (No)*

Does anyone in your family have a history of: *(Please check)*

6. Y / N ❒Breast Cancer ❒Colon Cancer ❒Ovarian Cancer ❒Uterus Cancer ❒Diabetes ❒Osteoporosis ❒Heart Disease ❒Hypertension ❒Heart Attack/Stroke before age 50 ❒Blood clots requiring blood thinners
7. Y / N Have you ever had a blood clot in your legs or lungs and placed on blood thinners?
8. Y / N Do you want information on domestic violence?
9. Y / N Do you consistently eat foods that are fried or high in fat?
   Date of your last cholesterol screen: _________________________
10. Y / N Any history of a sexually transmitted disease? ❒Herpes ❒Chlamydia ❒Gonorrhea ❒Trichomoniasis ❒HPV ❒Syphilis ❒Other___________________________________
11. Y / N Any history of an abnormal PAP with precancer (dysplasia) or cancer?
    If yes, when, ___________________ Treatment: ____
12. Y / N Do you use tobacco products? If yes, _________ pack(s) per day
13. Y / N Do you use alcohol products? If yes, _________ drink(s) per day
14. Y / N Do you use illegal/recreational drugs?
15. Y / N Have you ever had any surgery? If yes, PLEASE LIST ______________________________________
    ____
16. Y / N Any chronic (long-term) medical problems? If yes, PLEASE LIST __________________________
    ____
17. Y / N Have you any significant, persistent change in your bowel movements or blood in your stool?
18. Y / N Do you exercise for more than 30 minutes, 3-5 times weekly?
19. Y / N Do you perform breast self exam monthly?
20. Y / N Do you take a calcium supplement?
21. Y / N If you are over 40, have you had a baseline mammogram this year?
    Date of last Mammogram _____________________
22. Y / N If you are 50 or older, have you ever had a sigmoidoscopy/colonoscopy?
    If yes, date of last exam _________________________
23. Y / N If you are 60 or older, has your thyroid ever been checked? If yes, when? _______________________
24. Y / N If postmenopausal, have you ever had a bone density test? If yes, when? _______________________
25. Y / N Have you completed an Advance Directive Will? *(Living Will)*

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 medication.

Patient / Guardian Signature: ___________________________________ Date: ___________________________

Counseled / Doctor's Signature: _________________________________ Date: ___________________________

Julie D. Schneider, MD