



**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  Any Problem(s)?  Yes  None

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: \_\_\_\_\_