

# PATIENT QUESTIONNAIRE



NAME \_\_\_\_\_

## REASON FOR VISIT

## PAST MEDICAL & FAMILY HISTORY

PLEASE CHECK (✓) IF YOU (SELF) OR ANY BLOOD RELATIVE (FAM) HAD ANY OF THE FOLLOWING CONDITIONS

	SELF	FAM		SELF	FAM
1 WT LOSS-GAIN		<input type="checkbox"/>	15 BLOOD TRANSFUSIONS	<input type="checkbox"/>	
2 HEADACHES / MIGRAINE	<input type="checkbox"/>	<input type="checkbox"/>	16 ANEMIA / BLOOD DISORDER	<input type="checkbox"/>	<input type="checkbox"/>
3 HEART <input type="checkbox"/> VALVULAR DIS DISEASE <input type="checkbox"/> RHEUMATIC DIS <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	17 VARICOSE VEINS / PHLEBITIS	<input type="checkbox"/>	<input type="checkbox"/>
4 HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	18 SKIN DISEASE	<input type="checkbox"/>	<input type="checkbox"/>
5 HIGH CHOLESTEROL	<input type="checkbox"/>	<input type="checkbox"/>	19 DIABETES	<input type="checkbox"/>	<input type="checkbox"/>
6 RESPIRATORY DISEASE PULMONARY (LUNG)	<input type="checkbox"/>	<input type="checkbox"/>	20 THYROID DISEASE	<input type="checkbox"/>	<input type="checkbox"/>
7 BREAST DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	21 CANCER (TYPE)	<input type="checkbox"/>	<input type="checkbox"/>
8 JAUNDICE / HEPATITIS	<input type="checkbox"/>	<input type="checkbox"/>	22 EPILEPSY / NEUROLOGICAL DIS	<input type="checkbox"/>	<input type="checkbox"/>
9 HIATAL HERNIA (REFLUX)	<input type="checkbox"/>	<input type="checkbox"/>	23 ARTHRITIS - JOINT PAIN	<input type="checkbox"/>	<input type="checkbox"/>
10 PEPTIC ULCER (STOMACH)	<input type="checkbox"/>	<input type="checkbox"/>	24 OSTEOPOROSIS (FRAGILE BONES)	<input type="checkbox"/>	<input type="checkbox"/>
11 BOWEL DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	25 ANXIETY / DEPRESSION	<input type="checkbox"/>	<input type="checkbox"/>
12 KIDNEY DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	26 SLEEP PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>
13 URINARY INCONTINENCE	<input type="checkbox"/>	<input type="checkbox"/>			
14 URINARY INFECTIONS	<input type="checkbox"/>	<input type="checkbox"/>			

## HOSPITAL ADMISSIONS

LIST THOSE OPERATIONS & SERIOUS ILLNESS' WHICH REQUIRED HOSPITALIZATION (EXCLUDING PREGNANCY)

YEAR	REASON FOR ADMISSION / HOSPITAL	YEAR	REASON FOR ADMISSION / HOSPITAL

## MEDICATIONS

LIST ALL MEDICATIONS - YOU ARE CURRENTLY TAKING (DOSAGE - FREQUENCY) - INCLUDE OVER THE COUNTER DRUGS


DRUG ALLERGIES

## MENSTRUAL HISTORY

AGE AT FIRST PERIOD \_\_\_\_\_

IF MENSTRUATING - DATE OF LAST PERIOD (1st day) \_\_\_\_\_

PERIOD INTERVAL <b>Number</b> (1st day to 1st day) - <b>of days</b>	DURATION OF BLEEDING	CRAMPS <b>Y</b> <input type="checkbox"/> <b>N</b> <input type="checkbox"/>	<input type="checkbox"/> MILD <input type="checkbox"/> SEVERE <input type="checkbox"/> MOD. <input type="checkbox"/> ALWAYS PRESENT	MEDICATIONS <b>Y</b> <input type="checkbox"/> <b>N</b> <input type="checkbox"/>	FOR CRAMPS <b>Y</b> <input type="checkbox"/> <b>N</b> <input type="checkbox"/>
HOW MANY PERIODS IN THE LAST YEAR	BLEEDING (SPOTTING) BETWEEN PERIODS <b>Y</b> <input type="checkbox"/> <b>N</b> <input type="checkbox"/>				

## VAGINAL INFECTIONS

- History of  YEAST  TRICHOMONAS  CHLAMYDIA  HERPES  GONORRHEA  BACTERIAL VAGINOSIS

## PAP TEST

DATE OF LAST TEST  NORMAL  ABNORMAL **MAMMOGRAM** DATE OF LAST TEST  NORMAL  ABNORMAL

## CONTRACEPTIVE HISTORY

CURRENT METHOD \_\_\_\_\_ IF PILL - BRAND \_\_\_\_\_ PAST METHODS \_\_\_\_\_

## OBSTETRICAL HISTORY

- **Number of** PREGNANCIES \_\_\_\_\_ PREMATURE BABIES \_\_\_\_\_ MISCARRIAGES \_\_\_\_\_ ABORTIONS \_\_\_\_\_ LIVING CHILDREN \_\_\_\_\_

BORN YEAR / MOS.	WEEKS PREG.	WT	SEX	TYPE OF DELIVERY	REMARKS	BORN YEAR / MOS.	WEEKS PREG.	WT	SEX	TYPE OF DELIVERY	REMARKS
1						4					
2						5					
3						6					

## MENOPAUSAL HISTORY

If Applicable - HOT FLASHES **Y**  **N**  TREATMENT - \_\_\_\_\_

## TESTS

CHOLESTEROL  BONE DENSITY  COLON / RECTAL

## SEXUAL HISTORY

SATISFACTORY  UNCOMFORTABLE  WISH TO DISCUSS

## SOCIAL HISTORY

SMOKING CIG / DAY \_\_\_\_\_ # YEARS \_\_\_\_\_ ALCOHOL OZ / WK \_\_\_\_\_ COFFEE CUPS / DAYS \_\_\_\_\_ STREET DRUGS \_\_\_\_\_