

**ESTABLISHED PATIENT QUESTIONNAIRE**

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Reason for Today's Visit: \_\_\_\_\_

**Relationship Status:** Single Married Divorced Widowed Life Partner Significant Other

Number of Children: \_\_\_\_\_ Ages of Children: \_\_\_\_\_

Age at first period \_\_\_\_\_ Age at menopause (if applicable) \_\_\_\_\_

First Day of last menstrual period: \_\_\_\_\_

When was your last Pap test? (month and year): \_\_\_\_\_

Have you ever had an abnormal Pap test? YES NO

If yes, when and what treatment did you receive? \_\_\_\_\_

Are you sexually active? YES NO Not currently

If yes, is/are your partner(s): Male Female Both

**Type of birth control/protection currently used:**

Not having sex (Abstinence)	Condoms	Injection	Patch
IUD (Intrauterine Device)	Partner's vasectomy	Pills (Brand) _____	
Tubal Ligation	Other _____	NONE	

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**CURRENT MEDICATIONS (INCLUDING SUPPLEMENTS AND HERBS)**

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Are you allergic to any medications? YES NO If yes, please list medication and reaction :

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**Any new surgeries since last visit? (Please list type and date of surgeries)**

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**Review of Systems:** Please circle any of the following you have now.

**Skin:** psoriasis acne eczema dry skin

**Breast:** implants pain lump

**Head:** headaches vision disturbance hearing problem dizziness

**Respiratory:** cough wheezing shortness of breath

**Cardiac:** heart racing skipping beats high blood pressure

**GI:** nausea vomiting reflux diarrhea constipation hemorrhoids

**GYN:** irregular periods heavy bleeding cramps pain with sex spotting between periods  
bleeding after sex hot flashes night sweats vaginal dryness

History of sexually transmitted disease

**GU:** stress incontinence urgency getting up at night to void frequency burning

**Musculo-skeletal:** muscle aches leg cramps arthritis joint pain

**Endocrine:** thyroid diabetes polycystic ovarian syndrome galactorrhea

Have you ever had a mammogram? YES NO When was your last one? \_\_\_\_\_

Have you ever had a bone density test? YES NO When was your last one? \_\_\_\_\_

Have you ever had a colonoscopy? Yes NO When was your last one? \_\_\_\_\_

### FAMILY HISTORY

Has your family history changed since last visit? If so please list relative and age of diagnosis.

Cancer? YES NO \_\_\_\_\_

Diabetes? YES NO \_\_\_\_\_

Hypertension? YES NO \_\_\_\_\_

Heart Disease? YES NO \_\_\_\_\_

Epilepsy? YES NO \_\_\_\_\_

Birth Defects? YES NO \_\_\_\_\_

Problems with Anesthesia? YES NO \_\_\_\_\_

### SOCIAL HISTORY

Occupation \_\_\_\_\_

Full time    Part time    Retired

**Education:**    High School    2 year college    4 year college    Post graduate

**Alcohol use.** Do you drink alcohol? YES NO How many drinks per week? \_\_\_\_\_

**Tobacco use.** Do you use tobacco? YES NO How many cigarettes do you smoke a day? \_\_\_\_\_

If not currently, did you ever use tobacco? YES NO #of years \_\_\_\_ Year quit \_\_\_\_\_

Do you need help to quit? YES NO

**Drugs use.** Do you currently use recreational or street drugs? YES NO

**Caffeine use.** None    Occasional    Moderate    Heavy    # of cups/cans per day \_\_\_\_

**Exercise Level:** None    Occasional    Moderate    High level    How often? \_\_\_\_\_

How much calcium (servings or milligrams) do you get in a day? \_\_\_\_\_

Have you ever been or are you currently being abused physically, emotionally, or sexually? YES NO

Are you afraid of your spouse/partner/significant other? YES NO

Would you like to be tested today for sexually transmitted disease? YES NO

For patients under the age of 26:

Have you had the Gardasil Vaccine? YES NO

If no, would you like to get the vaccine? YES NO

**PATIENT SIGNATURE:** \_\_\_\_\_