

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	

CURRENT MEDICATIONS (INCLUDING SUPPLEMENTS AND HERBS)

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

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

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: _____