PATIENT QUESTIONNAIRE

PATIENT NAME____DOB______________________

LOCAL PHARMACY NAME______________________________CITY____________________________________

MAIL AWAY PHARMACY NAME____

ALLERGIES:

Name of medication	Type of reaction

LATEX ALLERGY: YES/NO

MEDICATIONS: (Please list any prescribed medications and supplements)

Name	Dosage	Frequency

SOCIAL HISTORY:

ALCOHOL________________TOBACCO____________________DRUGS________________________________

OCCUPATION____

MARITAL STATUS____

CURRENT MEDICAL PROBLEMS:

(Ex: hypertension, diabetes, thyroid disease, asthma, depression, heart disease, anemia, cancer etc.)

SURGICAL HISTORY:

(Ex: LEEP, D&C, laparoscopy, cesarean section, tubal ligation, hysterectomy, non-gynecologic surgeries)

FAMILY HISTORY: (Please check all that apply)

Type	Father	Mother	Father's parents	Mother's parents	Siblings	Children
Breast Cancer						
Ovarian Cancer						
Uterine Cancer						
Colon Cancer						
Cervical Cancer						
Endometriosis						
Osteoporosis						
Fibroids						
Diabetes						
High Blood pressure						
Heart Disease						
Other(s)						

OBSTETRICAL HISTORY:

(Please fill out the following pregnancy grid. Please include miscarriages and abortions.)

#	YEAR	HOSPITAL WHERE DELIVERED	LENGTH OF PREGNANCY IN WEEKS	HOURS IN LABOR	TYPE OF DELIVERY (Normal, Forceps, Vacuum, Cesarean)	SEX M/F	BIRTH WEIGHT	COMPLICATIONS

PREGNANCY COMPLICATIONS: (Circle all that apply)

ANEMIA BLEEDING BLOOD TRANSFUSION RH INCOMPATIBILITY SEIZURES

DIABETES HYPERTENSION JAUNDICE KIDNEY/BLADDER ISSUES PLACENTA PREVIA

PREMATURE LABOR PRE-ECLAMPSIA OTHER (Explain)___________________________________

IF NEGATIVE BLOOD TYPE, WAS RHOGAM RECEIVED? ____

GYNECOLOGY HISTORY:

MENSTRUAL CYCLE BEGAN AT_____ (AGE IN YEARS)

USUAL NUMBER OF DAYS BETWEEN CYCLES_________

USUAL NUMBER OF DAYS OF FLOW_________

DATE OF LAST CYCLE_____________

DATE OF LAST PAP SMEAR__________________________________NORMAL/ABNORMAL

HISTORY OF ABNORMAL PAP SMEAR: (Circle one) **YES NO**

TREATMENT FOR ABNORMAL PAP____

Are you sexually active now? **YES NO** In the past? **YES NO**

Have you ever been touched or forced to have sexual contact with someone against your will? **YES NO**

Are you currently having any of the following?

- □ Bleeding after menopause
- □ Amenorrhea (no periods for at least 3 months)
- □ Heavy or irregular periods (explain)____
- □ Bleeding between periods or after intercourse
- □ Painful periods
- □ Sexual difficulties
- □ Painful intercourse
- □ Infertility
- □ Did your mother take DES while pregnant with you?
- □ Pelvic pain
- □ Endometriosis
- □ Frequent bacterial/yeast infections
- □ Urinary incontinence (leakage of urine)
- □ Straining with urination
- □ Burning with urination
- □ Urinary urgency
- □ Any other gynecologic problems____

STD HISTORY:

◻ Herpes ◻ Hepatitis B or C ◻ Venereal warts	◻ Trichomonas ◻ Chlamydia ◻ Gonorrhea	◻ HIV ◻ HPV ◻ Syphilis

FORM OF CONTRACEPTION:

- ◻ Oral contraceptives
- ◻ Nuva ring
- ◻ Depo provera
- ◻ IUD
- ◻ Nexplanon
- ◻ Tubal Ligation
- ◻ Partner with vasectomy
- ◻ Abstinence
- ◻ Condoms
- ◻ Other________________________________
- ◻ None

If patient is a minor:

If you are unable to accompany your minor to her appointment, list the name (s) of the responsible adult (s) that has your permission to be present during the examination.

Name_______________________________________Relationship_____________________________________

Name_______________________________________Relationship_____________________________________

Patient
Signature____Date______________________________