

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)						

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:

<input type="checkbox"/> Herpes	<input type="checkbox"/> Trichomonas	<input type="checkbox"/> HIV
<input type="checkbox"/> Hepatitis B or C	<input type="checkbox"/> Chlamydia	<input type="checkbox"/> HPV
<input type="checkbox"/> Venereal warts	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> 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 _____