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PATIENT QUESTIONNAIRE

Please bring this completed form to your scheduled appointment (DO NOT MAIL).

Name: ______________________ Age: ________ Date/Time: ______________

What brings you to the office today:

____

Who referred you to our office:

____

Do you have any questions, problems, or concerns that you would like to discuss with us today?

____

____

MEDICATIONS

Please list all medications including herbal, supplemental, and OTC

____

____

____

Peanut allery: Yes ☐ No ☐

Drug allergies: Yes ☐ No ☐ *If yes, please specify:* ______________________

Which other physicians are you currently under the care of?

1) ____

2) ____

3) ____

SURGICAL HISTORY

Please list all surgeries – gynecological, plastic or other. Please include date/year: ______________

____

____

PAST MEDICAL HISTORY

- ☐ Allergies (Food, seasonal, environmental)
- ☐ Anemia
- ☐ Anesthesia Complications
- ☐ Anxiety Disorder
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Birth Defects or Inherited Disease
- ☐ Blood Transfusion
- ☐ Breast Cancer
- ☐ Breast Problem
- ☐ Cancer
- ☐ Deep Vein Thrombosis
- ☐ Depression/Postpartum depression
- ☐ Dermatologic Disorders
- ☐ Diabetes
- ☐ Eating Disorders
- ☐ Endometriosis
- ☐ Gestational Diabetes
- ☐ Heart Problems
- ☐ Hematologic Disorders
- ☐ Hepatitis/Liver Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ (IVF or FBT)
- ☐ Kidney or Bladder problems
- ☐ Lung Disease
- ☐ Neurologic/Epilepsy
- ☐ Osteoporosis
- ☐ Ovarian Cancer
- ☐ Polycystic Ovary Syndrome
- ☐ Pre-Eclampsia
- ☐ Prostate Issues
- ☐ Stroke
- ☐ Thrombophilia (Blood clotting disorder)
- ☐ Thyroid Problems
- ☐ Varicosities

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SCREENING HISTORY

Date of Last Colonoscopy: ____________________

Most Recent Bone Density: ____________________

Shingles Vaccine: Yes ☐ No ☐ Tdap Vaccine: Yes ☐ No ☐ Pneumococcal Vaccine: Yes ☐ No ☐

Measles Vaccine: Yes ☐ No ☐ Mumps Vaccine: Yes ☐ No ☐ Rubella Vaccine: Yes ☐ No ☐

Gardasil (HPV Vaccine): Yes ☐ No ☐

SOCIAL HISTORY

SUBSTANCES

Do you or have you ever smoked tobacco?

☐ Never Smoker ☐ Former Smoker ☐ Current everyday smoker ☐ Current some days smoker

Do you or have you ever used any other forms of tobacco or nicotine? Yes ☐ No ☐

If yes, do you or have you ever used e-cigarettes or vape? ☐ Never ☐ Former ☐ Current

What is your level of alcohol consumption? ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Do you use any illicit or recreational drugs? ☐ Yes ☐ No

If yes, which illicit or recreational drugs have you used? ____________________

MARRIAGE AND SEXUALITY

What is your relationship staus?

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partner

Are you sexually active? Yes ☐ No ☐ *Do you use protection during sex?* Yes ☐ No ☐

Occupation: ____________________

FOR WOMEN ONLY

GYNECOLOGICAL HISTORY

MENSTRUAL HISTORY

Age period started (menarche): ____________________

Date of Last Menstrual Period (LMP): ____________________

Duration of flow (# of days your period lasts): ____________________

Type of flow: Light ☐ Moderate ☐ Heavy ☐ Cramps: Yes ☐ No ☐

Frequency of cycle (days between periods): ____________________

SCREENING HISTORY

Date of last Pap Smear: ____________

History of Abnormal Pap: Yes ☐ No ☐

Most recent mammogram: ____________

Date of Abnormal Pap: ____________

Result of Abnormal Pap: ____________

SEX HISTORY

Sexually Active? Yes ☐ No ☐ Virgin? Yes ☐ No ☐ STIs/STDs? Yes ☐ No ☐

Current birth control method: ☐ Pills ☐ IUD ☐ Depo-Provera ☐ Natural/backing ☐ Vasectomy

☐ Vaginal Ring ☐ Tubal Ligation ☐ Condoms ☐ Abstain ☐ Nexplanon ☐ Other ____________

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FOR WOMEN ONLY

OBSTETRICAL HISTORY

Number of Pregnancies ____________ Vaginal deliveries ____________ C-Section ____________

Abortions ____________ Miscarriages ____________ Ectopic ____________

PERIMENOPAUSE/MENOPAUSE

Urinary Incontinence: Yes ☐ No ☐ Hormone Replacement Therapy: Yes ☐ No ☐

Hot Flashes: Yes ☐ No ☐ Night Sweats: Yes ☐ No ☐

Irregular Bleeding: Yes ☐ No ☐ Mood Changes: Yes ☐ No ☐

Sexual Problems: Yes ☐ No ☐ Mental Health Issues: Yes ☐ No ☐

Sleep Problems: Yes ☐ No ☐ Joint/Muscle Pain: Yes ☐ No ☐

Weight Gain: Yes ☐ No ☐

If post-menopausal, age of menopause: ______________________________

FAMILY HISTORY

Please list medical problems associated with close family members

> especially cancer, heart disease, high BP, Diabetes

Father: Alive Yes ☐ No ☐ Age now or age of death ______ Medical Problems ______________________________

Mother: Alive Yes ☐ No ☐ Age now or age of death ______ Medical Problems ______________________________

Brother: (#) ______ Medical Problems ______________________________

Sister: (#) ______ Medical Problems ______________________________

Grandmother: Maternal ______________________________ Paternal ______________________________

Grandfather: Maternal ______________________________ Paternal ______________________________

Children: Boys (#) ______ Girls (#) ______ Medical Problems ______________________________

Other relevant medical problems (Aunts/Uncles) ______________________________

NOTICE TO PATIENTS

Medical doctors and midwives are licensed and regulated buy the Medical Board if California. To check up on a license or file a complaint go to **www.mbc.ca.gov** or email **licensecheck@mbc.ca.gov**.

______________________________ x ______________________________

Print Name Signature

This signature acknowledges the receipt of notice and understanding.