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Return Patient Medical Questionnaire

Date: ________________ Name: ____

Date of Birth: _________________________ Age: ___________

Reasons for this Visit/Complaints:

1. ____
2. ____
3. ____
4. ____

Tests: Have you had any one of these tests listed below? Please list the most recent and date.

Mammogram:	Pap Smear:
Bone Density:	GYN Exam
Pelvic Ultrasound:	Lipid Panel:
Colonoscopy:	Polyps? Yes or No

Bone Health: Have you ever been diagnosed with: Osteoporosis, Yes No Osteopenia, Yes No
Have you broken any bones? Yes or No Which bone/s ____
How did it happen? ____
Do you take Calcium? Yes or No Vitamin D? Yes or No Which kind and how often? ____________________
Do you take any bone medications such as Fosamax, Boniva, Actonel, Evista, or other? How long?___________

History of Periods: How old where you when you started your period? ___________
Are you in menopause? Yes or No At what age?______If, *yes,* go to the next section (history of sex)
First day of last menstrual bleeding: ___/___/___.
If this bleeding was **NOT** normal, when was the first day of your last normal period? ___/___/___.
Do you have regular periods? Yes or No
Do you bleed heavy? Yes or No
How often do you bleed? (from first day of bleeding to the first day of your next bleeding) Every ____days.
How many days do you bleed? ____days. Are they painful? Yes or No: If yes, severe, moderate or mild.
Have you had a new baby or adopted since your last visit? Yes No
Adopted C-section Vaginal

History of Sex:
Are you currently sexually active? Yes or No
If no, when was the last time you had sex? __months __years ago.
If yes, do you use any kind of birth control? Yes or No
If yes, which type of birth control: Tubal ligation, hysterectomy, partner had vasectomy, birth control pill, IUD, Depo Provera injections, condom, ring, patch, implant, vaginal spermicides, other _____________.

History of Bladder: Do you have problems holding urine? Yes, No, Sometimes, Rare.
If no, go to next section (history of bowel)
Do you wet yourself when you sneeze, cough, or laugh? Yes, No, Sometime, Rare
Do you have urgency to urinate? Yes, No, Sometimes, Rare
Do you wet yourself because you could not make it to the bathroom on time? Yes, No, Sometimes, Rare
Do you have urinary frequency? Yes, No, Sometimes, Rare
Do you use pads? Yes or No
Do you lose urine without feeling it? Yes or No

History of Bowel: Do you have problem controlling bowel movements (soiling yourself)? Yes or No
Do you have regular bowel movements? Yes or No If no, please explain______________________________
____

Hormones: Do you have hot flashes? Yes or No Do you get night sweats? Yes or No
Do you take hormones? Yes or No What kind? ________________ Dose____________________
How often? Daily, Weekly, Twice Weekly, Monthly, Every 3 months? How long have you been using? _______

Are there any changes in your health since your last visit? Have you been diagnosed with any new disease?____
____

Have you been hospitalized or had any new surgery since your last visit? Please include reason, type of surgery, where and the name of the surgeon:
____
____
____

Current Medications: Please include over-the-counter medications and dietary supplements. Please list the name of the medication, dose and how long you have been taking the medicine:

1.
2.
3.
4.
5.
6.

Are you currently using or in the past have used any of the following:(circle)
Xanax Valium Lorazepam Librium Lortab Percocet Vicodin Morphine
Any other prescription pain killers or sleeping pills for longer than one month? ___________________
Reason: (circle) Back Pain Depression Insomnia Other type of pain Addiction

Allergies: (circle) If answer is yes, list the names of the drug, food or reason for the allergy.
Drug / Medication Yes No
____
Food Yes No ____
Environmental Yes No ____

Marital Status (Circle): Have you divorced or married since last visit? Yes No

____

Have you had a change in Jobs? Yes No

____

Habits: (circle) TOBACCO: Yes No If yes, ____ packs per day for ____years. Quit____months/years ago
ALCOHOL: Yes No If yes: Wine Beer Liquor, ____oz, ____times a week, Rarely
PRESCRIPTION PAIN KILLERS: Yes No
NON PRESPCRIPTION / STREET DRUGS: Yes No

Exercise: Do you exercise? Yes No Sometimes What type? ______________________________
How often? ___________________ each exercise session lasts ________________minutes.

Family: Are there any new diseases, or deaths in your family since your last visit? Yes No

____

Vaccinations: HPV/Gardasil? Yes or No If yes, is the series complete? Yes or No
Influenza this year? Yes or No Pneumococcal? Yes or No When?__ Td/Tdap? Yes or No When?____
Zoster/Shingles? Yes or No

Patient Signature: ___________________________________Date:_________