



# Established Patient History Questionnaire

Please answer all questions carefully prior to your visit. Answers are confidential.

Would you like a female chaperone? Yes ( ) No ( )

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_ Length of time since last general exam \_\_\_\_\_ Months

**Interval medical history:** (Please circle either yes or no and explain if yes.) **Since your last full check up here, have you had any illnesses or medical problems?** .YES / NO \_\_\_\_\_  
**tests or x-rays?**.....YES / NO \_\_\_\_\_  
**surgeries or been hospitalized ?**..YES /NO \_\_\_\_\_  
**new information** regarding your family medical history?..YES / NO \_\_\_\_\_  
**vaccinations ?**.....YES / NO \_\_\_\_\_

Please list your **ALLERGIES:** \_\_\_\_\_

Please list your current **MEDICATIONS** (including dose and frequency: \_\_\_\_\_

**Interval GYN history:** If you are in your reproductive years, please answer these questions about your reproductive history since you last visit here. Circle either yes or no, and explain if yes. The date of your last menstrual period \_\_\_\_\_

Have your periods changed a lot?.....YES / NO \_\_\_\_\_

Have you had any pregnancies?.....YES / NO \_\_\_\_\_

Have you changed your method of contraception?....YES / NO \_\_\_\_\_

Are you regularly using contraception for sexual activity?.....YES / NO (circle type) the pill / minipill / Depo-Provera  
tubal ligation / vasectomy / IUD / diaphragm / condom / Norplant / rhythm / cap

YES / NO Are you content with your sex life?

YES / NO How many sexual partners have you had in the past year? \_\_\_\_\_ (circle) male female

**Interval social history:** (Please circle either yes or no and explain if yes.)

Has there been a change in your marital status since you last annual exam?....YES / NO \_\_\_\_\_

Has there been a change in your employment or occupation? .....YES / NO \_\_\_\_\_

Have there been significant changes in your lifestyle or daily routine?.....YES / NO \_\_\_\_\_

**Alcohol:** Do you currently drink alcohol? YES / NO Quit date: \_\_\_\_\_

Glasses per week usually consumed: wine \_\_\_\_\_ beer \_\_\_\_\_ cocktails \_\_\_\_\_ other \_\_\_\_\_

Have you ever felt that you should cut down on your drinking?.... YES / NO

Have your ever felt bad or guilty about your drinking?.....YES / NO

**Smoking:** Are you currently a smoker?.....YES / NO Quit Date: \_\_\_\_\_

Number of cigarettes per day smoked now: \_\_\_\_\_ Other tobacco products used now? .....YES / NO \_\_\_\_\_

**Drugs:** Recreational drugs used now?.....YES / NO (circle): marijuana, cocaine, heroin, speed, hallucinogen, other \_\_\_\_\_

**Emotional health:** Have you been experiencing any emotional or mood problems? .....YES / NO

In the past year, have you had 2 weeks or more during which you felt sad, blue, or depressed,  
or when you lost all interest or pleasure in things that you usually cared about or enjoyed? .....YES / NO

**Alternative medicine** Do you use any alternative or complementary forms of medicine? .....YES / NO

(circle) herbal remedies acupuncture homeopathy therapeutic touch chiropractic magnetic other:

CONTINUED ON BACK...

**Safety:** Please answer the following:

- YES / NO Do you wear seatbelts regularly?
- YES / NO If you cycle, do you wear a bicycle/motorcycle helmet?
- YES / NO Do you have smoke detectors in your home?
- YES / NO If you smoke detector has batteries, have you checked/changed them in the last year?
- YES / NO Are there adequate handrails for any stairs in your home?
- YES / NO **If** you have young children, is the thermostat on your water heater turned down?
- YES / NO **If** you own a gun,, is it secured away from children?
- YES / NO Do you practice safe sex ( monogamous relationship or condom use)?
- Are you being hit or verbally abused at home or elsewhere? .....YES / NO
- Are you now, or have you ever been forced to have sex without your consent? .....YES / NO

**Health Maintenance**

- YES / NO Do you eat a balanced diet with plenty of fruits and vegetables and low in fat?
- YES / NO Do you participate in regular physical activity or exercise? How often? \_\_\_\_ times per week  
What types of exercise? \_\_\_\_\_
- YES / NO Do you visit the dentist in the last year? How many times? \_\_\_\_\_
- YES / NO Do you brush and floss daily?
- YES / NO Has your cholesterol level ever been checked? Date: \_\_\_\_\_ Value: \_\_\_\_\_
- YES / NO Have you ever had a Pap smear? Date of most recent Pap smear: \_\_\_\_\_
- YES / NO Do you do monthly breast self exam?
- YES / NO Have you ever had a mammogram? Date of most recent mammogram: \_\_\_\_\_
- YES / NO Did you have an eye exam in the past year with glaucoma screening?
- YES / NO Do you check your skin periodically for unusual growths or changes in moles?
- YES / NO Do you wear sunscreen when out of doors?

**What are your health concerns or problems today?** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- |                             |                              |                            |                           |
|-----------------------------|------------------------------|----------------------------|---------------------------|
| ___ pre-conception concerns | ___ sexual difficulties      | ___ sexually transmissible | ___ abnormal moles        |
| ___ cancer screening        | ___ nutrition                | ___ diseases               | ___ marital counseling    |
| ___ weight loss             | ___ exercise programs        | ___ HIV testing            | ___ parenting issues      |
| ___ smoking cessation       | ___ alcohol or drug problems | ___ PMS                    | ___ stress reduction      |
| ___ domestic violence       | ___ incontinence (urine or   | ___ vaginitis              | ___ depression counseling |
| ___ home safety             | stool leakage)               | ___ menopause              | ___ cholesterol           |
| ___ contraceptive options   | ___ safe sex                 | ___ vaccinations           | ___ fibroids              |
| ___ infertility             | ___ hormone replacement      | ___ breast exam            | ___ _____                 |
| ___ menstrual difficulties  | ___ osteoporosis             | ___ vitamin supplements    | ___ _____                 |

**Patient signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **THANK YOU!**

<b>DOCTOR'S NOTES:</b>
<i>Clinician Signature</i> _____ <i>Date:</i> _____