Patient Questionnaire

Date: _____ **Name:**_____ **DOB:** _____
Height:_____ **Weight:** _____ **Last Menstrual Period:**_____
Previous/Current Primary Care Doctor:_____
Preferred Pharmacy: _____ **City Located:** _____
Reason for Today's visit: _____

Allergies: (circle/list any medications that apply below) _____No known medication allergies

Latex Sulfa Penicillin Codeine Other: _____
**If yes ; what is the reaction you experience for each allergy? _____
_____

Medications:

Name of Medication	Strength	# of tablets	How often do you take?	What are you taking it for?

Do you have a Living Will? Yes / No

Your own medical history: (Do you or have ever had any of the following problems)

Asthma Abnormal Cholesterol Blood Transfusion Chronic Pain Depression Disorder
Diabetes Frequent UTI Frequent Vaginal Infections Heart Disease High Blood Pressure
Hepatitis B Hepatitis C Infertility Kidney Disease Migraines Seasonal Allergies
Seizure STDs Stroke Thyroid Disease Varicose Veins

Pregnancy History:

# of pregnancies:_____ # of vaginal deliveries_____ # of C-Section deliveries_____

Have you ever had any of the following: (Please list the number of each on the line below)

miscarriage_____ abortion_____ ectopic pregnancy_____ delivery before 36wks_____

Surgical History: (if applicable, please complete below)

Name of surgery performed _____ Year_____

Name of surgery performed _____ Year_____

Hospitalizations: (if applicable, please list with dates *excluding* the above surgical **– include child births**)

Name of hospital _____Year_____

Name of hospital _____Year_____

Name of hospital _____Year_____

Family medical history: (check the family member who applies to the below problem list)

Problem	Mother	Father	Brother/Sister **(specify)**
Hypertension			
Stroke			
Abnormal Cholesterol			
Diabetes			
Cancer **(include type!)**			
Thyroid Problem			
Cardiac Disease			

Immunizations: (please provide the last date received, if known)

Are your immunizations up-to-date? Yes / No

Pneumonia shot:_____ Flu vaccine:_____ Tetanus shot:_____

TB skin test: Year _____ Result: Neg / Pos Chest X-Ray: _____ Result: Neg / Pos

Social history: Married Single Widowed Divorced Separated

# of living children: _____

*Sexual Orientat*ion: Heterosexual Lesbian Bi-Sexual Not Sexually Active Other:_____

Employed: _____ Unemployed: _____ Occupation: _____

Education: (circle highest level completed)
9th Grade 10th Grade 11th Grade High School /GED Some College Degree Program Masters

Lives with: spouse parent(s) children self partner other: _____

Tobacco Use: Current smoker Former smoker Never smoker
# of packs per day: _____ For how many years? _____

Alcohol Use: Occasionally Rarely Weekly None
How often per week? _____ For how many years? _____

Recreational Drug Use: Yes / No

Caffeine Use: Yes / No How much per day: _____ For how many years? _____

Preventative medication: (please list the month & year that these tests were last performed)

Pap smear: _____ Mammogram: _____ Bone Density:_____ Colonoscopy:_____

What form of birth control do you currently use?
Tubal Condoms OCP (pill) IUD Nexplanon None Other: _____

Have you ever had an abnormal pap? Year _____ Result_____ Treatment_____

Menstrual History:
Age began period: _____ # of days between periods: _____ How long period last: _____