Rue de Santé Women's Center

Patient Questionnaire

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Patient Name: _____ Age: _____ DOB: _____

Mailing Address: _____

Phone #: _____

What insurance do you have? (please provide insurance card):

_____

*In order for the physician to make the best medical decisions, please complete this questionnaire to the best of your knowledge.

Are you transferring from another physician? ____ If so, physician's name: _____

What is your weight? _____ How tall are you? _____

List all medications you take: _____

_____

List all past surgeries, including C-sections: _____

_____

Pregnant Patients ONLY, please answer below:

•How many times have you been pregnant? _____
•How many children do you have? _____
•Have you had any miscarriages?_____
•Have you had any stillborn births? _____
•When was your last period? _____
•Have you ever had a C-section? _____
•Have you ever had premature labor? _____
•Have you ever had twins? _____
•Have you ever had diabetes? _____
•Have you ever had high blood pressure? _____
•Have you ever had a venereal disease? _____
•Have you ever had a bladder infection? _____
•Have you ever or presently take drugs? _____
•Do you drink alcohol? _____
•Any other medical issues? _____
_____

Non-pregnant Patients ONLY, please answer below:

What are you being seen for?
□**Annual Office Visit/Pap Smear**
□**Abnormal Pap Smear Results**
Date of Last Pap Smear_____
Where Was Pap Smear Done? _____
Do you currently smoke? _____
Have you ever had the HPV shot? _____
Have you had surgery on your cervix? _____
□ **Birth Control/Tubal Ligation/Sterilization**
Are you currently on birth control? _____
If so, what one? _____
Are you married or in permanent relationship? ___
□**Abnormal Uterine Bleeding/Heavy Periods**
How often does your period occur? _____
How long does your period last? _____
How many pads or tampons per day? _____

Appointment Scheduled: _____Doctor:_____