COPLEY

PATIENT HISTORY QUESTIONNAIRE

Our goal is for you to be as healthy as possible. This is a detailed history form to get the big picture about your current health and your individual needs. Please print, complete and email this questionnaire prior to your visit.

PATIENT INFORMATION

Patient name (last, first, M.I): _____Preferred Name: _____
Gender Identity: ☑ Female ☐ Male ☐ Nonbinary ☐ Other: (specify) _____Date of birth:_____ Age: _____
Sex at birth: ☐ Female ☐ Male ☐ Intersex Pronouns: ☐ she/her ☐ he/him ☐ they/them ☐ other: _____

What is the reason for your visit today? _____
If you have symptoms, please describe how long, what treatments you have tried and any other important details.
_____
_____
_____

ALLERGIES

Do you have any allergies to any medications or foods? ☐ Yes ☐ No If yes, please list and describe the reaction. ie: Penicillins - hives

Allergy/Reaction	Allergy/Reaction

CURRENT MEDICATIONS

Include prescribed, over-the-counter drugs, folic acid or vitamins, herbal remedies or supplements, inhalers

Name of medication	Strength/dosage	Frequency taken	Reason for taking

HEALH MAINTENANCE HISTORY

When was your last pap test? _____ Was it normal? ☐ Yes ☐ No
Have you ever had an abnormal pap test? ☐ Yes ☐ No
Have you ever had: (Check all that apply and give date, approximate ok) ☐ Colposcopy_____ ☐ Cryotherapy_____
☐ LEEP_____ ☐ Cone biopsy_____ ☐ Laser treatment_____
When was your last:
Mammogram_____ Never had one Was it normal? ☐ Yes ☐ No
Colonoscopy_____ Never had one Was it normal? ☐ Yes ☐ No
DEXA (bone density scan)_____ Never had one Was it normal? ☐ Yes ☐ No
HIV test_____ Never had one What were the results? _____
Have you completed vaccination for Hepatitis B? ☐ Yes ☐ No
Have you completed vaccination for HPV (Gardasil/Cervarix/other)? ☐ Yes ☐ No

GYNECOLOGIC HISTORY

At what age did you have your first period?_____
Do you have a period approximately once a month? ☐Yes – go to yes ☐ No – skip yes, go to no

If YES:	**If NO:**
First day of your last period: _____ Do you have regular predictable periods? ☐Yes ☐ No How many days do you typically bleed?_____ How often do your periods occur (number of days from the start of one to the start of the next one?_____ Do you have any bleeding/spotting between periods? ☐Yes ☐ No Do you have any bleeding after sex? ☐Yes ☐ No Describe your flow: Light Moderate Heavy Is your period painful? ☐Yes ☐ No If yes, please describe:	What is the reason? Menopause Hysterectomy Endometrial ablation Breastfeeding Long-acting birth control Other:_____ At what age did you stop having regular periods?_____ Have you had any spotting or bleeding after menopause or hysterectomy?☐Yes ☐ No Have you ever been on hormonal therapy (estrogen and/or progesterone?) ☐Yes ☐ No

During the last three months, have you leaked urine (even a small amount)? ☐Yes ☐No

If yes, answer the following questions:

- During the last three months, did you leak urine (check all that apply):

  ☐When you were performing some physical activity, such as coughing, sneezing, lifting, or exercise?

  ☐When you had the urge or feeling that you needed to empty your bladder, but you could not get to the toilet fast enough?

  ☐Without physical activity and without a sense of urgency?

- Which of the above symptoms occurs most frequently? _____

SEXUAL/CONTRACEPTIVE HISTORY

Who do you have sex with? ☐Male partner ☐Female partner ☐Transgender partner ☐Other:_____
What types of sex do you have? ☐Genital (penis in the vagina) ☐Anal (penis in the anus) ☐Oral (mouth on penis, vagina or anus)
☐ Other (digital/finger or toys in vagina or anus)
How many partners do you currently have? _____ How many partners in the past 6 months? _____
Do you use condoms? ☐Yes ☐ No How often do you use condoms? ☐Never ☐Sometimes ☐Always

Have you ever had any of the following infections? ☐Chlamydia ☐Genital herpes ☐Genital warts ☐Gonorrhea ☐ Hepatitis B ☐
Hepatitis C ☐HIV/AIDS ☐HPV ☐Pelvic inflammatory disease (PID) ☐Trichomonas ☐ Syphilis ☐Other: _____

Do you have any pain or discomfort during sex? ☐Yes ☐ No
If yes, please describe your pain_____
Do you have any concerns or questions about sex such as questions about orgasm or decreased sexual desire? ☐Yes ☐ No
If yes, please describe _____

Current birth control method ☐None ☐Condoms ☐Diaphragm ☐ Natural family planning _____
☐Birth control pills: _____ ☐Patch ☐Ring ☐ DepoProvera injection ☐IUD: _____
☐Implanon/Nexplanon ☐Tubal ligation ☐Essure ☐ Vasectomy ☐Other: _____

If taking combined oral contraceptives, how often do you miss a pill or need to double up? _____
If taking progestin-only ("mini-pill"), how often do you take your pill outside of the three hour window?_____
Have you used emergency contraception in the past year? ☐Yes ☐ No If yes, how many times? _____

Are you happy with your current birth control method? ☐Yes ☐ No If no, would you like to discuss options? ☐Yes ☐ No

PREGNANCY HISTORY (skip if not applicable)

How old were you when you gave birth to your first child? _____

Total number of pregnancies _____Living children _____Full-term births_____ Premature births_____ Multiple births_____

Miscarriages _____ Terminations _____ Tubal pregnancies _____ Molar pregnancies _____

Have you been ever been diagnosed with: ☐ gestational diabetes ☐ gestational hypertension or pre-eclampsia ☐ preterm labor

REVIEW OF SYSTEMS Please check any of the following symptoms that you experience presently or chronically.

Constitutional	☐ Fatigue ☐ Fever/chills ☐ Sleep disturbance ☐ Unexpected weight change	**Endocrine**	☐ Cold or heat intolerance ☐ Glucose/Sugar problems ☐ Hair loss ☐ Excessive hair growth
Head and Neck	☐ Nasal congestion ☐ Nose bleeds ☐ Hearing loss ☐ Sensitivity to light ☐ Mouth sores ☐ Sore throat	**Urinary**	☐ Pain/burning on urination ☐ Difficulty urinating ☐ Urgency to urinate ☐ Blood in urine ☐ Frequent bladder or kidney infections ☐ Frequent urination If so, how many times/day?_____
Cardiovascular	☐ Murmur ☐ Chest pain ☐ Heart palpitations/racing heart ☐ Edema	**Respiratory**	☐ Cough ☐ Sleep apnea ☐ Wheezing ☐ Shortness of breath
Gastrointestinal	☐ Nausea/vomiting ☐ Diarrhea ☐ Constipation ☐ Hemorrhoids ☐ Abdominal pain ☐ Gas/Bloating ☐ Heartburn/Acid Reflux	**Gynecologic**	☐ Abnormal vaginal discharge ☐ Vaginal odor ☐ Burning or vulvar/vaginal discomfort ☐ Vaginal itching ☐ Genital lesions, bumps or ulcers ☐ Vaginal dryness ☐ Irritability ☐ Changes in your memory ☐ Hot flashes or night sweats
Central nervous system	☐ Headaches ☐ Dizziness ☐ Weakness or numbness ☐ Seizures	**Psychiatric**	☐ Anxiety ☐ Depression ☐ Bipolar disorder ☐ ADHD
Breast	☐ New or changing breast lump ☐ Dimpling, puckering or skin changes ☐ Tenderness or pain ☐ Nipple discharge ☐ Nipple changes	**Skin**	☐ Bruise or bleed easily ☐ Rash ☐ Varicosities

PAST MEDICAL HISTORY - Please check all health problems which **you** have now or have had previously.

☐ Acne	☐ High cholesterol	☐ Gallbladder disease	☐ Broken bones
☐ Other skin diseases	☐ Heart disease	☐ Hepatitis (any)	☐ Osteoporosis/bone loss
☐ Anemia	☐ Heart murmur	☐ Irritable bowel syndrome	☐ Arthritis
☐ Cancer	☐ High blood pressure	☐ Gluten insensitivity	☐ Joint problems
☐ Diabetes	☐ Asthma	☐ Acid reflux/GERD	☐ Scoliosis
☐ Thyroid disease	☐ Pneumonia	☐ Stomach ulcer	☐ Recurrent vaginal infections
☐ Migraine headaches	☐ COPD	☐ Ulcerative colitis/Crohn's	☐ Pelvic infections
☐ Seizures/Epilepsy	☐ Other lung disease	☐ Kidney infections	☐ Infertility
☐ Stroke/TIA	☐ Breast lump	☐ Recurrent bladder infection	☐ Endometriosis
☐ Lupus/+ ANA	☐ Breast discharge	☐ Overactive bladder	☐ Fibroids
☐ Other autoimmune disease	☐ Breast surgery	☐ Urinary incontinence	☐ Ovarian tumors/cysts
	☐ Breast biopsy	☐ HIV/AIDS	☐ Other
	☐ Blood clots (DVT)	☐ Depression	_____
	☐ Pulmonary embolus	☐ Anxiety	_____
	☐ Bleeding problems	☐ Bipolar disorder	_____
	☐ Blood transfusions	☐ ADHD	_____

SURGICAL HISTORY Please list all surgical procedures that you have had. Please include the date, reason for surgery and type of surgery:

Date	Type of Surgery	Reason

SOCIAL HISTORY

Do you have any religious or cultural preferences that may impact your care? ☐ Yes ☐ No

If yes, please describe _____

Are you: ☐ Single ☐ In a relationship ☐ Married ☐ Divorced ☐ Widowed Other: _____

What is your profession/occupation? _____

Do you eat at least 5 servings and vegetables per day? ☐ Yes ☐ No

Do you avoid any food groups or foods? If yes, please describe:_____

Do you drink caffeine (soda, tea, coffee)? ☐ Yes ☐ No If yes, type and number of cups per day_____

How do you like to joyfully move your body? How many times per month? _____

What are your hobbies/activities? _____

Would you like to discuss your weight today? ☐ Yes ☐ No

Do you wear your seatbelt every time you drive or ride in a vehicle? ☐ Yes ☐ No

Do you have a primary care provider? ☐ Yes ☐ No If yes, what is their name/practice? _____

Are there other medical or personal concerns that we have not asked you about which you would like to discuss in this visit?

☐ Yes ☐ No If yes, please explain: _____

FAMILY HISTORY – List Relationship to you (Parents, siblings, children, grandparents, aunts and uncles), their age at diagnosis and if they are still alive. Example: Breast cancer Maternal Grandmother: diagnosed age 49, deceased age 62

Disease/Condition	**Relationship/Age at Diagnosis**
Anemia	
Arthritis	
Asthma/Lung Problems	
Birth Defects	
Bleeding Problems	
Blood Clots (DVT)	
Breast Cancer	
Colon Cancer	
Total colon polyps 20 or more (precancerous or adenomas)	
Depression/Anxiety	
Diabetes	
Heart Attack (MI)	
Heart Disease	
High Cholesterol	
High Blood Pressure	
Kidney Disease/UTIs	
Liver Disease	
Metastatic Prostate Cancer	
Psychiatric conditions	
Osteoporosis/Bone Loss	
Ovarian Cancer	
Pancreatic Cancer	
Rectal Cancer	
Seizures	
Skin Cancer	
Stomach Cancer	
Stroke	
Substance abuse	
Thyroid Disease	
Uterine Cancer (not cervical)	
Other cancers, hereditary or familial diseases or disorders not addressed above:	