



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

HEALTH 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:

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:

If NO:

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

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

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