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 complete and email/mail this questionnaire prior to your visit.

## PATIENT INFORMATION

Patient name (last, first, M.I): _____Chosen Name: _____
Gender Identity: ☐ Female ☐ Male ☐ Nonbinary ☐ _____ Date of birth:_____ Age: _____
Sex assigned at birth: ☐ Female ☐ Male ☐ Intersex Pronouns: ☐ she/her ☐ he/him ☐ they/them ☐ _____

**What is the reason for your visit? _____ Date of visit:_____**
**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 |
|---|---|
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## CURRENT MEDICATIONS

Include prescribed, over-the-counter drugs, inserted or implanted devices (ie Nexplanon, IUD) folic acid or vitamins, herbal remedies or supplements, inhalers

| Name of medication | Strength/dosage | Frequency taken | Reason for taking |
|---|---|---|---|
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## 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 ☐ No

| **If YES:** | **If NO:** |
|---|---|
| First day of your last period: _____<br>Do you have regular predictable periods? ☐ Yes ☐ No<br>How many days do you typically bleed?_____<br>How often do your periods occur (number of days from the start of one to the start of the next one?_____<br>Do you have any bleeding/spotting between periods? ☐ Yes ☐ No<br>Do you have any bleeding after sex? ☐ Yes ☐ No<br>Describe your flow: ☐ Light ☐ Moderate ☐ Heavy<br>Is your period painful? ☐ Yes ☐ No If yes, please describe: | What is the reason?<br>Menopause Hysterectomy Endometrial ablation<br>Breastfeeding Long-acting birth control<br>Other:_____<br><br>At what age did you stop having regular periods?_____<br>Have you had any spotting or bleeding after menopause or hysterectomy? ☐ Yes ☐ No<br>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? ☐ Partner(s) with a penis ☐ Partner(s) with a vagina ☐_____
☐ Not currently having sex ☐ Have never had sex
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: _____
☐ 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<br>☐ Fever/chills<br>☐ Sleep disturbance<br>☐ Unexpected weight change | **Endocrine** | ☐ Cold or heat intolerance<br>☐ Glucose/Sugar problems<br>☐ Hair loss<br>☐ Excessive hair growth |
| **Head and Neck** | ☐ Nasal congestion ☐ Nose bleeds<br>☐ Hearing loss<br>☐ Sensitivity to light<br>☐ Mouth sores<br>☐ Sore throat | **Urinary** | ☐ Pain/burning on urination ☐ Difficulty urinating<br>☐ Urgency to urinate ☐ Blood in urine<br>☐ Frequent bladder or kidney infections<br>☐ Frequent urination If so, how many times/day?_____ |
| **Cardiovascular** | ☐ Murmur<br>☐ Chest pain<br>☐ Heart palpitations/racing heart<br>☐ Edema | **Respiratory** | ☐ Cough<br>☐ Sleep apnea<br>☐ Wheezing<br>☐ Shortness of breath |
| **Gastrointestinal** | ☐ Nausea/vomiting<br>☐ Diarrhea<br>☐ Constipation<br>☐ Hemorrhoids<br>☐ Abdominal pain<br>☐ Gas/Bloating<br>☐ Heartburn/Acid Reflux | **Gynecologic** | ☐ Abnormal vaginal discharge ☐ Vaginal odor<br>☐ Burning or vulvar/vaginal discomfort ☐ Vaginal itching<br>☐ Genital lesions, bumps or ulcers<br>☐ Vaginal dryness<br>☐ Irritability ☐ Changes in your memory<br>☐ Hot flashes or night sweats |
| **Central nervous system** | ☐ Headaches<br>☐ Dizziness<br>☐ Weakness or numbness<br>☐ Seizures | **Psychiatric** | ☐ Anxiety<br>☐ Depression<br>☐ Bipolar disorder<br>☐ ADHD |
| **Breast** | ☐ New or changing breast lump<br>☐ Dimpling, puckering or skin changes<br>☐ Tenderness or pain<br>☐ Nipple discharge<br>☐ Nipple changes | **Skin** | ☐ Bruise or bleed easily<br>☐ Rash<br>☐ Varicosities<br>☐ Eczema<br>☐ Psoriasis |

**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 sensitivity | ☐ 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 |
|---|---|---|
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| | | |
| | | |
| | | |

**Have you ever been hospitalized overnight?** ☐ Yes ☐ No If yes, please explain: _____

**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 of 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: dx age 49, alive; Paternal Aunt: dx age 55, deceased 56

| **Disease/Condition** | **Relationship, Age at Diagnosis, Age at death** |
|---|---|
| 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:** | |