PATIENT QUESTIONNAIRE

NAME_____AGE_____DATE_____

REASON FOR VISIT_____

ANY ALLERGIES TO MEDICINE_____

LIST ALL MEDICATIONS YOU ARE TAKING AT THE PRESENT TIME:_____

_____

LIST ALL PREVIOUS SURGERIES_____

_____

PERSONAL OR FAMILY HISTORY

DIABETES _____ SICKLE CELL DISEASE ___ _____ __

HIGH BLOOD PRESSURE _____ _____ BOWELS: CONSTIPATED____ _ NORMAL

CANCER ___ _____ URINARY PROBLEMS: YES OR NO

TUBERCULOSIS ___ _____ __

BREAST CANCER __ _____ ___

PREGNANCY HISTORY: TOTAL PREGNANCIES TO DATE_____

OTHER MEDICAL PROBLEMS:_____

DO YOU SMOKE: YES OR NO

DO YOU DRINK: YES OR NO

ANY HISTORY OF DRUG ABUSE: YES OR NO

LAST MENSTRUAL PERIOD _____

CYCLES: REGULAR_____ IRREGULAR_____

MENSTRUAL FLOW: LIGHT____ MODERATE____ HEAVY____ HOW MANY DAYS?____

MENSTRUAL PAIN: NONE____ MILD____ MODERATE____ SEVERE____

DISCHARGES: YES OR NO

HISTORY OF PELVIC PAIN: YES OR NO

HISTORY OF VAGINAL INFECTIONS: YES OR NO

ANY ADDITIONAL COMMENTS:

_____

_____

PATIENT SIGNATURE_____ DATE_____