



# Patient Information Questionnaire

## PATIENT INFORMATION

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
 Street Address: \_\_\_\_\_ Email: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
 Home Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Marital Status:  Single  Married  Divorced  Widowed  Separated  Other \_\_\_\_\_  
 Work Status:  Employed  Retired  Disabled  Self-Employed  Unemployed  Other: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Email: \_\_\_\_\_  
 Decision Maker in the Event of Emergency: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Decision Maker's Phone: ( ) \_\_\_\_\_  
 Pharmacy: \_\_\_\_\_ Pharmacy Phone #: ( ) \_\_\_\_\_

## PHYSICIAN INFORMATION

Primary Care Practice Name: \_\_\_\_\_ Physicians Name: \_\_\_\_\_  
 Primary Care Phy. Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

## REASON FOR VISIT

What is the reason for your visit:  Annual Exam  Obstetric first visit  GYN problem

If you are here for a problem what are your concerns? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## HEALTH MAINTENANCE / PREVENTIVE SCREENING

Colonoscopy	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes; date / /	Results:	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Dexa Scan	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes; date / /	Results:	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Mammogram	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes; date / /	Results:	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal

## PAP SMEAR

Pap smear	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes; date / /	Results:	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
LEEP	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes; date / /	Results:	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
History of HPV?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes; date / /			
Received HPV vaccine?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes; date / /	<input type="checkbox"/> Inj. 1	<input type="checkbox"/> Inj. 2	<input type="checkbox"/> Inj. 3

## PAST SURGICAL HISTORY *(within past 5 years)*

Year	Surgery	Complications?



**GENETIC SCREENING** None (Includes patient, baby's father, or anyone in either family)

Indicate Yes or No	Yes	No		Yes	No
Tay-Sachs			Maternal Metabolic Disorder		
Neural Tube Defect			Mental Retardation / Autism		
Sickle Cell Disease or Trait			Medication / Street Drugs/ Alcohol		
Thalassemia			Muscular Dystrophy		
Hemophilia			Huntington Chorea		
Cystic Fibrosis			Recurrent pregnancy loss or a still birth		
Down Syndrome			Other inherited genetics or chromosomal disorder		
Congenital Heart Defect			Patient or father of the baby had/has a child with birth defects not listed		

**GYNECOLOGY**

Age at first period:	Do you have concerns regarding you period? Describe:
Frequency of period:	
Length of period:	
1 <sup>st</sup> day (date) of last period:	Are you in menopause? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Describe Period: <input type="checkbox"/> Light <input type="checkbox"/> Normal <input type="checkbox"/> Heavy	Date of last period:
Current Contraceptive Method:	Are you on hormone replacement therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No

**OBSTETRICS**

	Number		Number
Total number of pregnancies		Abortions Induced	
Full Term Births		Miscarriages	
Pre-Term Births		Living Children	

No.	Birth Date	# Weeks at Delivery	Sex	Birth Weight	Delivery Type	Complications
1						
2						
3						
4						
5						
6						

**SOCIAL HISTORY**

**Are you currently sexually active?**  Yes  No If **Yes**, what age did you become sexually active? \_\_\_\_\_

**Current Sexual partner(s) is/are:**  Male  Female  Male and Female

**Have you ever had any sexually transmitted diseases? (STD's):**  Yes  No

If **Yes**, what kind? \_\_\_\_\_

**Are you interested in STD screening?**  Yes  No

**Do you use tobacco products?**  Yes  No If **Yes**, packs per day? \_\_\_\_\_ Number of years? \_\_\_\_\_

If **No**, have you ever? \_\_\_\_\_ When did you Quit? \_\_\_\_\_

**Do you use smokeless tobacco?**  Yes  No If **Yes**, packs per day? \_\_\_\_\_ Number of years? \_\_\_\_\_

If **No**, have you ever? \_\_\_\_\_ When did you Quit? \_\_\_\_\_

**Do you drink alcohol?**  Yes  No If **Yes**, how many drinks per week? \_\_\_\_\_ Wine \_\_\_\_\_ Beer \_\_\_\_\_ Liquor

**Do you use recreational drugs?**  Yes  No If **Yes**, use per week? \_\_\_\_\_ Type: \_\_\_\_\_

**LIFE STYLE**

**Do you exercise?**  Yes  No If **Yes**, how often? \_\_\_\_\_ Type: \_\_\_\_\_

**Do you live alone?**  Yes  No

**Do you feel safe at home?**  Yes  No

**Have you been a victim of abuse or domestic violence?**  Yes  No

**Do you perform self-breast exam?**  Yes  No

<b>Blood Transfusion / Products</b>	<b>Yes</b>	<b>No</b>	<b>If No, Please briefly explain why.</b>
Would you accept a blood transfusion or blood products in the event of a life threatening situation?			

**AUTHORIZATION AND RELEASE**

I hereby certify that I have completed the above information to the best of my knowledge. I authorize, consent, request, and agree to actively participate in such services as routine assessments, the performance of diagnostic tests and procedures, care and treatment as self-referred or as ordered by my physician, his/her assistant or designees.

\_\_\_\_\_  
(Patient or Legal Guardian) Signature

\_\_\_\_\_  
Date