Douglas Women's Center
Confidential Health Questionnaire

Name: _____ Date of Birth:____/____/____ Today's Date: ____/____/____

REASON FOR VISIT (Please check appropriate box)**:** ☐ **ANNUAL EXAM** ☐ **PROBLEM EXAM**

Please explain any problems or concerns:

CURRENT MEDICATIONS, VITAMINS AND HERBAL SUPPLEMENTS:

DRUG NAME:	DOSAGE:	DRUG NAME:	DOSAGE:	DRUG NAME:	DOSAGE:

DRUG ALLERGIES:

GYN HISTORY:

Last menstrual period or hysterectomy (Date) ____/____/____	Date of last pap smear ____/____/____
Periods: Regular □ Irregular □	History of Abnormal Pap Smears? Yes □ No □
How far apart are your periods?	Do you use any kind of birth control? Yes □ No □
How long does your period last?	Type: How Long?
Painful periods? Yes □ No □	Are you satisfied with this method? Yes □ No □
Are periods Light □ Moderate □ Heavy □	What other birth control methods have you used? List below:
Sexually active Yes □ No □	
Painful intercourse Yes □ No □	# pregnancies _____ # births: _____ # miscarriages: _____
Any vaginal discharge, itching or odor? Yes □ No □	Any urinary burning, frequency or pressure? Yes □ No □

REVIEW OF SYSTEMS:

Please mark (x) if any of the following apply to you now, in the past or often

	Current	Past		Current	Past
CONSTITUTIONAL			**URINARY**		
Weight Loss	□	□	Blood in Urine	□	□
Weight Gain	□	□	Pain with Urination	□	□
Fever	□	□	Urgency	□	□
Fatigue	□	□	Frequency of Urination	□	□
CARDIOVASCULAR			Incomplete Emptying	□	□
Chest Pain	□	□	Stress Incontinence	□	□
Swelling of Legs	□	□	**MUSCULOSKELETAL**		
Palpitations of Heart	□	□	Muscle Weakness	□	□
RESPIRATORY			**ENDOCRINE**		
Wheezing	□	□	Dry Skin	□	□
Spitting Up Blood	□	□	Abnormal Thirst	□	□
Shortness of Breath	□	□	Hot Flashes	□	□
GASTROINTESTINAL			**HEMATOLOGIC/LYMPHATIC**		
Diarrhea, frequent	□	□	Bruises, frequent	□	□
Bloody Stool	□	□	Cuts do not stop Bleeding	□	□
Nausea/Vomiting	□	□	Enlarged Lymph Nodes	□	□
Constipation	□	□	**PSYCHIATRIC**		
BREAST			Depression	□	□
Pain in Breast	□	□	Crying, Frequent	□	□
Discharge	□	□	Anxiety	□	□
Masses	□	□			

If you have checked any of the above, are you currently receiving treatment or evaluation for the conditions(s)?

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PERSONAL PAST HISTORY (Major Illnesses)

Illness	Yes	No	Illness	Yes	No
Asthma			Cancer (Specify Type)		
Chronic Lung Disease			Ulcers		
Kidney Infections/Stones			Depression/Anxiety		
History of Endometriosis			Anemia/Blood Transfusions		
Sexually Transmitted Disease			Seizures/Convulsions/Epilepsy		
Heart Trouble/Murmur			Bowel Trouble		
Diabetes			Glaucoma		
High Blood Pressure			Fracture		
Stroke			Hepatitis/Yellow Jaundice		
History of Fibroids			Thyroid Disease		
Any other illnesses not listed above? *If yes, please explain:*					
Any recent hospitalizations?			*Explain:*		
Any recent surgeries?			*Explain:*		
Any recent health issues?			*Explain:*		
Have you had a colonoscopy?			If Yes, When? ____/____/____		

ANY NEW FAMILY HISTORY?

Illness	Yes	No	Illness	Yes	No
Diabetes			Breast Cancer		
Stroke			Colon Cancer		
Heart Disease			Ovarian Cancer		
High Blood Pressure					
Other? (Please specify)					

SOCIAL HISTORY CHANGES:

Marital Changes? Yes □ No □

Married □ Single □ Widowed □ Divorced □

	Yes	No	
Alcohol			Drinks Per Day? _____ Drinks Per Week?_____
Drug Use			
Regular Exercise			
Smoking			Packs per day_____ # of Years _____

PLEASE CHECK ALL THAT APPLY:

□ I am due for a Mammogram
□ I am due for DEXA aka: Bone Density Screening (Performed Every Two Years)
□ I desire STD Testing
□ I desire Birth Control
□ I want to discuss Permanent Birth Control
□ I want blood work drawn
□ I want a pregnancy test today

PRIMARY CARE PHYSICIAN INFORMATION:

What is the name of your Primary Care Physician?: _____

Do you see your Primary Care Physician Yearly? Yes □ No □

When was the last time you visited your Primary Care Physician for an annual physical? _____