

**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:

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GYN HISTORY:

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

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

If you have checked any of the above, are you currently receiving treatment or evaluation for the condition(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?			<i>Explain:</i>
Any recent surgeries?			<i>Explain:</i>
Any recent health issues?			<i>Explain:</i>
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? _____