Women's Health Questionnaire for New Patient and for Annual Wellness Visit

Name: ____Date of Birth: _______________Today's Date: ________________
Primary Care Provider: ________________________Pharmacy: ___________________________ Pharmacy Location: ____________
New Patient to GRPC: ☐ Yes ☐ No New Patient to this provider: ☐ Yes ☐ No Do you have Advance Directives: ☐ Yes ☐ No

PAST MEDICAL HISTORY (Please check all that apply and indicate family member– M=mother, F= father, B=brother, S=sister):

Thyroid Disease	Myself: ____	Family:____ Who? __________	Rheumatoid Arthritis	Myself: ____	Family:____ Who? _______
Heart Attack or Coronary Artery Disease	Myself: ____	Family:____ Who? __________	Fibromyalgia	Myself: ____	Family:____ Who? _______
Blood Clots	Myself: ____	Family:____ Who? __________	Osteoporosis	Myself: ____	Family:____ Who? _______
High Blood Pressure	Myself: ____	Family:____ Who? __________	Alcoholism	Myself: ____	Family:____ Who? _______
High Cholesterol	Myself: ____	Family:____ Who? __________	Drug Addiction	Myself: ____	Family:____ Who? _______
Ulcerative Colitis	Myself: ____	Family:____ Who? __________	Depression	Myself: ____	Family:____ Who? _______
Gallstones	Myself: ____	Family:____ Who? __________	Anxiety	Myself: ____	Family:____ Who? _______
Crohn's Disease	Myself: ____	Family:____ Who? __________	Bipolar	Myself: ____	Family:____ Who? _______
Irritable Bowel Syndrome	Myself: ____	Family:____ Who? __________	Schizophrenia	Myself: ____	Family:____ Who? _______
Hepatitis	Myself: ____	Family:____ Who? __________	ADD/ADHD	Myself: ____	Family:____ Who? _______
COPD	Myself: ____	Family:____ Who? __________	Breast Cancer	Myself: ____	Family:____ Who? _______
Stomach Ulcer or Reflux	Myself: ____	Family:____ Who? __________	Ovarian Cancer	Myself: ____	Family:____ Who? _______
Kidney Stones	Myself: ____	Family:____ Who? __________	Cervical Cancer	Myself: ____	Family:____ Who? _______
Frequent Urinary Infections	Myself: ____	Family:____ Who? __________	Skin Cancer	Myself: ____	Family:____ Who? ______
Diabetes	Myself: ____	Family:____ Who? __________	Colon Cancer	Myself: ____	Family:____ Who? _______
Migraines	Myself. ____	Family. ____Who? __________	Other:______	Myself: ____	Family:____ Who? _______
Asthma	Myself: ____	Family:____ Who? _______	Other:______	Myself: ____	Family:____ Who? _______
Seizure Disorder	Myself: ____	Family:____ Who? _______	Other:______	Myself: ____	Family:____ Who? _______
CVA (stroke)	Myself: ____	Family:____ Who? _______	Other:______	Myself: ____	Family:____ Who? _______

Mother: ☐ Alive, age ____ ☐ Deceased at age ____ cause of death: ____
Father: ☐ Alive, age ____ ☐ Deceased at age ____ cause of death: ____

PAST SURGERY HISTORY (Please check all that apply and indicate year):

Tonsillectomy			Exploratory Laparotomy		
Thyroidectomy			Cosmetic Surgery **Specifiy:**_______________		
Gallbladder Removal			Varicose Vein Stripping		
Appendectomy			Bariatric Surgery		
Inguinal Hernia Repair			C-Section		
Hemorrhoidectomy			Tubal Ligation / Sterilization		
Joint Replacement **Specify:** ________________			Hysterectomy – partial (ovaries intact)		
Knee Arthroscopy			Hysterectomy – total (ovaries removed)		
Rotator Cuff Repair			Neck/back surgery		
Carpal Tunnel Release			Other:		
Colonoscopy			Other:		
Exploratory Laparoscopy			Other:		

OBSTETRICAL HISTORY:

Number of Pregnancies		Number of Living Children	
Number of Miscarriages/Abortions		Number of Vaginal Deliveries	
Number of Full Term Births		Number of Caesarian Sections	
Number of Premature Births			

GYN HISTORY:

History of infertility ☐ Yes ☐ No History of ovarian cysts ☐ Yes ☐ No History of Endometriosis ☐ Yes ☐ No

DES Exposure? ☐ Yes ☐ No Do you have problems with losing urine or feces? ☐ Yes ☐ No Age of first period: ______________

First day of last period ____________________ Cycle occurs every _____ days - Lasting _____ days or Age of Menopause__________

Periods are:		**Flow is:**	
Regular		Light	
Irregular		Light to Moderate	
Painful		Moderate to Heavy	
Not really bothersome		Heavy	

Are you sexually active? ☐ Yes ☐ No

Sexual Preference: ☐ heterosexual ☐ homosexual ☐ bisexual

Recent New Partner (< 1 year)? ☐ Yes ☐ No

Method of Birth Control? ____________________________

Have you ever had any STDs? (Please check all that apply and indicate year):

Chlamydia			Trichomonas		
Gonorrhea			HIV		
Herpes			Hepatitis B		
HPV			Hepatitis C		
Syphilis			Never had any		

Date of last pap smear: _________________________ ☐ normal ☐ abnormal

Have you ever needed any of the following for an abnormal pap smear? ☐Colposcopy ☐Cryosurgery ☐LEEP/Laser/Conization ☐ None

Date of last mammogram? ______________________ ☐ normal ☐ abnormal ☐ have not had one done

Date of last bone density? _____________________ ☐ normal ☐ low bone density ☐ Osteoporosis ☐ have not had one done

Date of last Colonoscopy ______________________☐ normal ☐ abnormal ☐ have not had one done

When was your last TDap shot? __________________When was your last cholesterol check? _________________

Last Dental Visit/Where?__________________ Last Vision Screening/Where?__________________ Last Hearing Test_________________

Communication requirements due to hearing, vision, or cognition? ☐ Yes ☐ No Explain: ______________________________________

SOCIAL HISTORY:

Occupation: _______________Highest level of education or grade completed:__________ Second hand smoke exposure? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes How many years? ____ How many packs per day? ____ ☐ Never ☐ Not anymore, I quit ____ years ago.

Do you drink alcohol? ☐ Yes How many drinks per week? ____ Type: ____________ ☐ Never ☐ Not anymore, I quit ____ years ago.

Do you use recreational drugs (marijuana) or illicit drugs? ☐ Yes ☐ No Type: ____

Do you have difficulty interacting socially? ☐ Yes ☐ No Explain: ____

Housing/living situation concerns (safety issues, access to healthy food, transportation problems)☐ Yes ☐ No Explain:__________________

Trauma history (physical/emotional/sexual abuse, PTSD,other) ☐ Yes ☐ No Explain:____

MEDICATIONS: (Prescriptions, Vitamins, Herbal/Alternative Meds)

Are you allergic to any medications? ☐ Yes ☐ No What? ____

List any medications you are taking including prescription, over the counter, vitamins, and herbal/alternative meds:

Current Medication and indication	Dosage	Prescribed by:

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Do you have trouble affording the care or prescriptions prescribed? ☐ Yes ☐ No Explain:____

Patient Signature: ____ Date____________________________