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OB/GYN
Excellence in Women's Health is our Legacy

Patient Name: _____ Date: _____

Date of Birth: _____ Age: _____

Pharmacy Name and Location: _____

Return Annual Patient Questionnaire

Do you have any specific symptoms or concerns you would like to discuss today? _____
_____

Have there been any new diagnoses, illness, or significant changes to your personal or family history since your last visit? _____
_____

Have you had any surgeries or procedures since your last visit? _____
_____

Have you been seen by any other physicians or been hospitalized since your last visit?_____
_____

MEDICATIONS: Please include prescribed, over the counter, vitamins, supplements, etc. **(Please include dosage)**

1) _____ 3)_____ 5)_____
2) _____ 4)_____ 6)_____

ALLERGIES: Yes No **If yes,** please list and include reaction: _____

GYNECOLOGICAL HISTORY:

Do you still have cycles? Yes No

If yes, First day of last menstrual cycle: _____

How frequent do your periods come? Every _____ days OR _____ month(s) How long do your periods last? _____

Are your period's heavy? Yes No **If yes**, how many pads/tampons do you use per day? _____

Do you experience *significant cramping* with your period? Yes No Do you spot between periods? Yes No

If no, Age at menopause: _____ or Hysterectomy: _____ Any issues with hot flashes? Yes No

Are you currently sexually active? Yes No Have you been sexually active in the past? Yes No

If yes, your current partner(s) is/are? Male Female Have you had any new sexual partners in the past year? Yes No

What type of contraception do you use currently (if applicable): Contraceptive Pills Condoms IUD Patch Ring
DepoProvera Rhythm Method Withdrawal Vasectomy Tubal Ligation None Abstinence Nexplanon

Have you ever had an abnormal Pap smear? Yes No Date of last Pap smear? _____

Do you have any current issues with incontinence or loss of urine? Yes No **If yes**, please describe _____

Do you examine your breasts regularly? Yes No Any current breast problems or changes?_____

OBSTETRICAL HISTORY:

Have you ever been pregnant? Yes No

If yes, please indicate Total number of pregnancies_____ No. of Deliveries____ No. of Losses_____

PREVIOUS TESTS/IMMUNIZATIONS:

Colonoscopy	Yes	No	Date: _____	Mammogram	Yes	No	Date: _____
Cardiac Screen	Yes	No	Date: _____	Bone Density	Yes	No	Date: _____
Gardasil	Yes	No	Date: _____	Other _____			

Please list any new vaccinations in the past year? _____

SOCIAL HISTORY:

What is your marital status?_____

What is your occupation? _____ What is your partner's occupation? _____

Do you use TOBACCO? Never Current Past **If yes**, Cigarettes a day _____ for # of years_____

Do you drink ALCOHOL? Yes No **If yes**, Drinks per week# _____ OR Drinks per month_____

Do you use recreational drugs? Yes No **If yes**, please describe: _____

Do you exercise? Yes No **If yes,** how many days a week? _____

REVIEW OF SYSTEMS: Please check any ***current, significant*** symptoms

Constitutional
____ Fatigue
____ Weight Change
____ Fever/ Chills

Cardiovascular
____ Chest Pain
____ Palpitations

Respiratory
____ Wheezing
____ Coughing
____ Shortness of Breath

Gastrointestinal
____ Abdominal Pain
____ Blood/ Change in Stool
____ Nausea/Vomiting

Genitourinary
____ Painful Urination
____ Frequency of Urination
____ Blood in Urine
____ Leakage of Urine

Endocrine
____ Excessive Thirst
____ Hair Loss
____ Cold or Heat Intolerance

Musculoskeletal/Skin
____ Joint/Muscle Pain
____ Swelling in legs
____ Easy bruising or bleeding
____ Change in Mole/Lesion
____ Rash/Itching

Mood
____ Depression
____ Anxiety

Neurologic
____ Headaches
____ Weakness

Please list your Primary Care Doctor and all health practitioners/specialists that you are currently seeing:

Physician Name Phone/Location

1) _____
2) _____
3) _____
4) _____