

Bergen Ob-Gyn

PROGRESSIVE WOMEN'S MEDICINE. PERSONALIZED, COMFORTABLE CARE.

Health Questionnaire - Please fill out both sides completely.

Name: _____ Age: _____ Date: _____

Reason for today's visit: Annual Exam Problem Consultation Other: _____

Age when your periods started: _____ First day of last menstrual period: _____

Are your periods regular? Yes No How often do you get your period? _____ (skip if postmenopausal)

How many days of bleeding? _____ How would you describe the flow? Light Moderate Heavy

Have you noticed a recent change in bleeding? Yes No If yes, describe: _____

Are your periods painful? Yes No Is your pain relieved by over-the-counter medications? Yes No

Are you sexually active? Yes No # of partners: _____ Any pain or bleeding with intercourse? Yes No

Current birth control method:

None Condoms Diaphragm Pills Patch Ring IUD Tubes tied Partner's vasectomy

Are you satisfied with this method? Yes No

When was your last pap smear? _____

Have you ever had an abnormal pap test? Yes No

If yes, when & how was this treated? _____

Do you have any abnormal vaginal discharge? Yes No

If yes, mark any other symptoms: Itching Burning Bad odor Other: _____

Have you ever had: (please check off all applicable boxes)

Recurrent vaginal infections Gonorrhea Chlamydia Trichomonas Herpes Frequent urinary infections

Was it treated? Yes No Were there any related complications? Yes No

Do you want to be tested for sexually transmitted diseases? Yes No

Are you having any problems with urination? Yes No

Any other symptoms? Burning with urination Bloody urine Frequent urination Loss of urine involuntarily

Have you ever been pregnant? Yes No Are you currently trying to get pregnant? Yes No

Total # pregnancies: _____ # Living: _____ # Abortions: _____ # Miscarriages: _____

Date	Type of Delivery	Weight	Sex	Complications	Child's Name

Please check off all medical conditions that you or your family have been diagnosed with: (P = patient, F = family)

Condition	P	F	Details	Condition	P	F	Details
Heart Disease				Gastrointestinal/Ulcers			
Hypertension/Stroke				Uterine Fibroids			
Pulmonary/Asthma/Emphysema				Blood Disorder			
Liver Disease/Hepatitis				Skin Ca/Eczema/Psoriasis			
Kidney Disease				Osteopenia/Osteoporosis			
Diabetes				Breast Cancer			
Thyroid Dysfunction				Ovarian Cancer			
Autoimmune Disorder				Uterine Cancer			
Neurologic/Epilepsy/Migraines				Colon Cancer			
Psychiatric/Anxiety/Depression				Pancreatic Cancer			

Please list any other medical conditions not listed: _____

Have you ever had a surgical procedure? Yes No If so, please list the date and type of each procedure: _____

Have you ever been hospitalized for some reason other than surgery? Yes No If so, please list the date and reason for each hospital stay: _____

Are you taking any medications, supplements or herbs? Yes No If so, please list: _____

Are you allergic to any medications? Yes No If so, please list the medication and reaction: _____

Have you ever had a mammogram? Yes No If so, when was your last test? _____

Are you doing a self breast exam? Yes No If yes, do you check monthly? Yes No

Have you noticed any new lumps or changes? Yes No Do you have any nipple discharge? Yes No

Have you ever had a colonoscopy? Yes No If so, when was your last test? _____

Have you ever had your cholesterol checked? Yes No If so, when? _____

Have you ever had your thyroid hormones checked? Yes No If so, when? _____

Do you smoke cigarettes? Yes No How many per day? _____

How much alcohol do you drink in a typical week? _____

Do you use any recreational drugs? Yes No If so, what and how often? _____

How much calcium (servings or milligrams) do you get in a day? _____

What do you do for exercise? _____ How often? _____

Are you afraid of your spouse/partner/significant other? Yes No

Please check any new problems you have experienced recently: (check all that apply)

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Fever/Chills | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Change in bowel habits |
| <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Black stools |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Visual changes | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Back pain |
| <input type="checkbox"/> Weight loss/gain | <input type="checkbox"/> Severe headaches | <input type="checkbox"/> Excessive swelling | <input type="checkbox"/> Joint pain |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Blackouts/falling | <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Anxiety/depression |
| <input type="checkbox"/> Dizziness/lightheadedness | <input type="checkbox"/> Numbness/tingling | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Swollen glands |
| <input type="checkbox"/> Change in hearing | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Excessive bleeding |
| <input type="checkbox"/> Loss of speech | <input type="checkbox"/> Frequent coughing | <input type="checkbox"/> Constipation | <input type="checkbox"/> Excessive bruising |

Do you have any other symptoms or problems not mentioned anywhere else? Yes No

If yes, please describe: _____

Any other comments/suggestions: _____

Thank you for taking the time to provide this information.

Patient Signature: _____ Date: _____