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
Disability Status: ☐ Yes ☐ No If yes, please explain: _____

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:

Regular		Light	
Irregular		Light to Moderate	
Painful		Moderate to Heavy	
Not really bothersome		Heavy	

Have you ever had any STDs? (Indicate year):

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

Are you sexually active? ☐ Yes ☐ No

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

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:_____

Gender Identity: ☐ Male ☐ Female ☐ Trans Male/Trans Man ☐ Trans Female/Trans Women ☐ Genderqueer/Gender Nonconforming ☐ Other Identity _____

Sexual Preference: ☐ heterosexual/straight ☐ homosexual ☐ bisexual ☐ other _____

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:

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

Patient Signature: _____ Date_____