NORTHWEST HOSPITAL
a LifeBridge Health center

WOMEN'S WELLNESS CENTER
PATIENT QUESTIONNAIRE

Name: ___________________________________ **Date of Birth:** ___________

Best phone number(s) to reach you:

1: __________________________ 2:___________________________

Referred by: _________________________ **Primary Care MD:** _________________

List any significant medical conditions (high blood pressure, diabetes, asthma …):

1.____________________ 2.____________________ 3.______________________

4.____________________ 5.____________________ 6.______________________

7.____________________ 8.____________________ 9. ______________________

List the date and reason for any surgeries, hospitalizations and/or invasive procedures:

1.__________________________________ 2.___________________________________

3.__________________________________ 4.___________________________________

5.__________________________________ 6.___________________________________

List all medications currently being taken:

1._____________________ 2._____________________ 3.______________________

4._____________________ 5._____________________ 6.______________________

7._____________________ 8._____________________ 9.______________________

10.____________________ 11.____________________ 12.____________________

List any drug allergies:

1.__________________________________ Reaction: ____________________________

2.__________________________________ Reaction: ____________________________

3.__________________________________ Reaction: ____________________________

4.__________________________________ Reaction: ____________________________

Do you have any family history of: (list relation affected)

Diabetes: _____________________ High Blood Pressure: _________________________

Stroke: _____________________ Breast Cancer: _________________________

Other Cancers: _______________ Other: _____________________________________

Name: ___________________________________

Date of last menstrual period: _____________ □ N/A

Date of last Pap Smear: _____________ □ N/A

Date of last Mammogram: _____________ □ N/A

Date of last Colonoscopy: _____________ □ N/A

Date of last Dexascan (Bone Density): _____________ □ N/A

Date of completion of (HPV)
Human Papillomavirus vaccine series: _____________ □ N/A

****

We understand that the following questions are sensitive in nature although Dr. Taber believes that in order to treat her patients in a holistic manner, the following information is important. Please answer every question.

1. Are you Single _____ Divorced _____ Widowed _____
2. With whom do you live? ________________________________
3. What is your occupation? ________________________________

   If retired, past occupation:_____________________________
4. Are you currently sexually active? _____

   If no, date of last sexual encounter: ___________
5. Current birth control: ____ □ N/A
   (This includes vasectomy, condoms, tuballigation)
6. What birth controls (Depo, pills, IUD) have you used in the past? _____________________

   List any problems related to these: ______________________________________
7. How old were you when you had your first menstrual cycle? _______ years old.
8. Any history of Sexually Transmitted Diseases including Herpes, HIV, Trich, Chlamydia?

   If so, list dates: ____.
9. Any history of abnormal pap smears?

   If so, list dates and procedures related to these (Colposcopy, Biopsy, Leep):
   ____.

10. Any bladder problems (prolapse, incontinence, blood in urine, previous procedures)?

    If so, please describe: ____.

11. Any history of breast problems (abnormal mammograms).

    If so, please describe: ____.

12. Do you smoke? _____ How much? __________ For how long? __________

    Are you interested in help with quitting? __________

13. How many alcohol drinks per wk? __ Has alcohol ever been a problem for you? __

    If so, are you interested in talking with anyone about it? __________

14. Do you use any recreational drugs? ____

15. Do you exercise? _____

    If so, how much? ___________________ For how long? _________________

16. What is your religion? ____

17. What is your sexual preference?

    Heterosexual _____ Homosexual _____ Bisexual _____

18. Are there any particular concerns that you have that you would like us to know about?

    ____

    ____

    ____

    ____

    ____

    ____

    ____

    ____

    ____

Review of Systems

(Answer Yes or No and Briefly Describe)

Skin and Hair:
Rashes? ______________________________

Moles that have changed? ________________

Hair falling out? ________________________

Eyes:
Change in vision? ________________

Glasses? ________________________

Cataracts? _______________________

Constitutional:
Fever? __________________________________

Unplanned weight gain or loss? ______________

Chills? _________________________________

Ears, Nose, Throat:
Hearing loss? ___________________

Sinus or nasal problems? __________

Difficulty swallowing? ____________

Lungs:
Problems breathing? ________________________

Chronic cough? ___________________________

Any relation to exertion? ____________________

Heart:
Chest pain? ______________________

Heart racing? ____________________

Any relation to exertion? __________

Gastrointestinal:
Recurrent indigestion or heartburn? ____________

Constipation or diarrhea? ____________________

Abdominal pain? __________________________

Bloody or black tarry stools? _________________

Musculoskeletal:
Joint or back problems? ___________

Recurrent muscle cramps? _________

History of fracture? ______________

Genitourinary:
Sexual problems? __________________________

Burning with urination? _____________________

Frequent urination? _________________________

Neurologic:
Headaches? _____________________

Loss of consciousness? ___________

Tremors? _______________________

Breasts:
Lumps? _________________________________

Discharge? ______________________________

Pain? ___________________________________

Self-exams? ______________________________

Breast-feeding? ___________________________

Endocrine:
Hot or cold intolerance? ___________

Frequent urination? ______________

Change in appetite? ______________

Sweating? _______________________

Excessive thirst? _________________

Psychiatric:
Constant irritability? _______________________

Fatigue? __________________________________

Sleep problems? ____________________________

Hematologic:
Frequent bruising? _______________

Bleeding disorders? ______________