

**Please help us provide the best healthcare for you by completing this questionnaire. Your answers will become part of your CONFIDENTIAL medical record.**

**If you have questions about a question, please skip it and discuss it with the nurse when you are brought back for your appointment.**

**Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Appt date\_\_\_\_**

**Preferred name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Age\_\_\_\_\_\_\_ Preferred pronoun\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Preferred pharmacy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Would you like a chaperone for your exams?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**When we call you with results, etc, can we leave a detailed message?\_\_\_\_\_\_\_\_\_\_\_\_**

**What is your #1 concern?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Your Medical History **(include any information you think relevant)**

**History of sexually transmitted disease\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**History of sexual abuse/trauma\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Abnormal pap history\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Painful sex\_\_\_\_\_\_\_\_\_\_\_\_**

**Breast problems\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Endometriosis\_\_\_\_\_\_\_\_\_\_\_\_\_**

**History of painful ovarian cysts\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Frequent UTIs\_\_\_\_\_\_\_\_\_\_\_**

**Loss of urine\_\_\_\_\_\_\_\_\_\_**

**Prolapse (dropped bladder/sagging support)\_\_\_\_\_\_\_\_ pessary use?\_\_\_\_\_\_\_\_**

**Cancer (even if in the past)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Postpartum depression\_\_\_\_\_\_\_\_\_\_**

**Mental health disorder\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Eating disorder\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Diabetes\_\_\_\_\_\_\_\_\_\_\_\_**

**High blood pressure\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Heart disease\_\_\_\_\_\_\_\_\_\_\_\_\_**

**History of heart attack\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Kidney disease\_\_\_\_\_\_\_\_\_**

**Liver disease/hepatitis\_\_\_\_\_\_\_\_\_\_\_**

**History of blood transfusion\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**History of a blood clot\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Bleeding disorder (von Willebrand’s, factor V, etc)\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Thyroid problems\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Neurologic problems (epilepsy, etc)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**History of stroke\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Varicose veins\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Seasonal allergies\_\_\_\_\_\_\_\_\_\_\_\_**

**Respiratory disease (asthma, TB, emphysema, etc)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Infertility\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Uterine anomaly\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Skin disease/condition\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Any genetic mutation that you know you carry?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you content with your weight?\_\_\_\_\_\_\_\_\_\_\_\_ Do you want to talk about it with provider?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Age of first period (menarche)\_\_\_\_\_\_\_\_\_\_\_**

**Last menstrual period\_\_\_\_\_\_\_\_\_\_\_\_\_ Menopause? (no period in 1 full year)\_\_\_\_\_\_\_**

**How long does your flow last?\_\_\_\_\_\_\_\_\_ How many days between periods?\_\_\_\_\_\_**

**Is your period too heavy or painful for you?\_\_\_\_\_\_\_\_\_**

**Are you on any hormonal medicines?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Would you like to get pregnant in the next year?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What is your current contraception?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**When was your last pap test (if this is not your first ever!)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Was it normal?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_last HPV test (if you know)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Last mammogram (if ever) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Was it normal?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you do a monthly breast exam on yourself?\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Last colonoscopy (if ever)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Was it normal?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Last bone density test (if ever)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Was it normal?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you ever had a pelvic ultrasound (not for pregnancy)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you had an HPV vaccine such as Gardisil?\_\_\_\_\_\_\_\_\_ All 3 injections?\_\_\_\_\_\_\_\_**

**Pap smear guidelines and recommendations for when to test have changed! Please help us tailor testing to you: YES/NO**

**Have you had at least 3 normal paps in your lifetime?\_\_\_\_\_\_\_\_**

**Did you have sex before age 16?\_\_\_\_\_\_\_\_\_\_**

**Have you had 5 or more sexual partners in your lifetime?\_\_\_\_\_\_\_**

**Were you, your mother, or grandmother exposed to DES (diethylstilbestrol)?\_\_\_\_\_**

**If over age 30, do you have a new sexual partner?\_\_\_\_\_\_\_\_\_\_\_**

**Have you ever been pregnant?(if no, skip this section)\_\_\_\_\_\_\_\_\_\_**

**Age of first pregnancy\_\_\_\_\_\_\_\_\_\_**

**Number of pregnancies\_\_\_\_\_\_\_\_\_\_\_\_**

**Number of live full term (over 37 weeks gestation) deliveries\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Number of live preterm deliveries (20 weeks to 36w6days)\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Number of stillbirths\_\_\_\_\_\_\_ (please give info you think pertinent) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Number of miscarriages\_\_\_\_\_\_\_\_\_\_\_\_\_ (please give info you think pertinent) \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Number of terminations\_\_\_\_\_\_\_\_\_\_\_\_\_ (please give info you think pertinent) \_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Tell us about your deliveries (date, location, type of delivery, weight of baby, etc) \_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Did you breastfeed? Issues? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Your Surgical History **(include any information you think relevant)**

**Hysterectomy (removal of uterus)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Removal of ovaries or fallopian tubes?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Tubal ligation/sterilization?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Cervix treatments? (LEEP, conization, cryo?)**

**Breast surgeries?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**C-sections\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Other surgeries\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Medications/Supplements **(include any info you think relevant-nurse will review with you) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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Allergies **(include any information you think relevant)**

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Social History **(include any information you think relevant)**

**Single/Married/Divorced/Widowed/Engaged/with a life partner, etc?\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you sexually active?\_\_\_\_\_\_\_\_\_\_\_with men/women/both?\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Would you like to be sexually active but are not?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you drink alcohol?\_\_\_\_\_\_\_\_\_\_\_\_\_If yes, how much per week?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you smoke cigarettes?\_\_\_\_\_\_\_\_If yes, how much/day\_\_\_\_\_\_\_\_ # of years\_\_\_\_**

**Do you use marijuana?\_\_\_\_\_\_\_\_\_\_\_\_\_\_Including CBD\_\_\_\_\_\_\_**

**Do you use other street drugs or recreational drugs?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you want to talk to provider about buprenorphine/opioid use disorder treatment?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Who lives in your household (ie: my 2 kids, my teenage niece, and a new puppy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you feel safe at home?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you exercise?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Occupation?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you in school?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Family History **(include any information you think relevant)**

**Diabetes\_\_\_\_\_\_\_\_\_\_\_**

**High blood pressure\_\_\_\_\_\_\_\_\_\_\_**

**Heart disease\_\_\_\_\_\_\_\_\_\_\_\_**

**Kidney disease\_\_\_\_\_\_\_\_\_\_**

**Liver disease\_\_\_\_\_\_\_\_\_\_\_**

**Lung disease\_\_\_\_\_\_\_\_\_\_\_**

**Neurologic disease\_\_\_\_\_\_\_\_\_\_\_\_**

**Skin disease\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Osteoporosis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Genetic disorders\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PLEASE SEE HEREDITARY CANCER SCREENING WORKSHEET**

**Any DES exposure? (Diethylstilbestrol was given to women in 1940-1971)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Ovarian cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Breast cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Uterine cancer/endometrial cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Colon cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Other cancers\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Blood clots or bleeding disorder\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Thank you for taking this time to help us take care of you!**