Place Label Here

NORTHWEST WOMEN'S CLINIC

Patient History Questionnaire

Today's Date:_____

Name:_____ Preferred name:_____Date of Birth:_____Height:_____

1. Reason for today's visit: _____
   _____
2. Family Medical History: Have any of your immediate relatives (mother, father, siblings or grandparents) experienced any of the following medical conditions? ***PLEASE INDICATE IF MATERNAL OR PATERNAL SIDE***
   - Heart Disease_____
   - Osteoporosis_____
   - Depression_____
   - Cancer_____
   - High Blood Pressure_____
   - Migraine_____
   - Anemia_____
   - Stroke_____
   - Kidney Disease_____
   - Epilepsy_____
   - Ulcer_____
   - Thyroid Disease_____
   - Breast Cancer_____
   - Diabetes_____
   - Colon Cancer_____
   - Arthritis_____
   - Other_____
3. Please list any hospitalization, surgeries or major illnesses you have had (dates, if possible):_____
   _____
4. Have you had any of the following? (if checked please indicate dates)
   - Allergies/Hayfever_____
   - Anemia_____
   - Anesthesia Complications____
   - Anxiety/depression/mood____
   - Asthma/Lung Disease_____
   - Birth defects_____
   - Cancer_____
   - Chicken Pox_____
   - Connective tissue disorder____
   - Diabetes_____
   - Thyroid/Endocrine_____
   - DVT/Clotting disorder_____
   - Endometriosis_____
   - GI problems_____
   - Hepatitis_____
   - Renal Disease/Bladder problems
   - Heart disease_____
   - Hypertension_____
   - Infertility_____
   - Neurological disease_____
   - Migraine_____
   - Recent weight loss/gain_____
   - Other_____
5. Please list any medications you are currently taking, including supplements: _____
   _____

Place Label Here

6. Please list any known drug allergies and reaction: _____
_____

7. OB/GYN history:
Initial age when period started___ First day of last period_____ How long do they last?___ Frequency of cycles_____
Date of last pap smear:_____ Was it normal?_____ Any history of abnormal paps? Y / N
Have you ever been diagnosed with a venereal disease? Y / N Please specify:_____
Do you perform monthly breast exams? Y / N If no, explain why_____
Date of last Colonoscopy: _____ Date of last Dexa Scan (bone density scan) _____
Date of last Mammogram_____
Primary Care Provider: _____
Pharmacy of Choice: _____
What method of birth control do you use?_____
Number of pregnancies: _____ Number of live births (please list below) _____
# of premature births____ # of induced abortions:___ # of miscarriages:___ # of multiple pregnancies:___ # of ectopics:____

What is your occupation?_____
Marital status:
Married Single Divorced Separated
Widowed Domestic Partner In a relationship
Spouse/Partners Name:_____
Religion / Social Note (optional) _____

Have you ever had vaginal intercourse: Y / N
Are you sexually active now? Y / N
Have you recently had sex with a new partner? Y / N
Your last sexual partner was: Male / Female
Have you had intercourse against your will? Y / N

Have you previously or currently been abused by your partner? Y / N – Verbal Physical Emotional Sexual
Do you smoke? Y / N If yes, how much? _____
Do you drink alcohol? Y / N If yes, how much? NONE OCCASIONAL MODERATE HEAVY
Do you or have you used street drugs? Y / N If yes, what type, how often? _____
Do you exercise? NONE OCCASIONAL (1-3 / wk) MODERATE (5-7 / wk) HEAVY (7+ per wk)
Diet: REGULAR VEGETARIAN VEGAN GLUTEN FREE DIABETIC SPECIFIC:_____
Is a blood transfusion acceptable in a medical emergency? Y / N