Patient Questionnaire and Review of Systems

Patient Name _____ Date of birth _____ Date of visit _____

Have you been ill recently? Y / N
What symptoms _____
Weight Gain / Loss Amount _____
Have you seen another physician recently Y / N
What type/reason _____
Have you been hospitalized recently? Y / N
When, where, reason _____

Age menstrual periods started _____
First date of last menstrual period _____
How often does cycle occur _____
How long does cycle last _____ Regular Y / N
Cycles are: Light, Moderate, Heavy, Clots
Pain with your cycle; None, Mild, Moderate, Severe.
Bleeding between your cycles _____
Menopausal Y / N History of hysterectomy Y / N

Sexual activity currently active / not currently active
How many sexual partners have you had _____
How long have you been with your current partner ____
History of sexually transmitted disease Y / N
If yes, what type _____
Are your current sexual relations satisfactory to you Y/N

Last pap smear (date/result) _____
Last mammogram (date/result) _____
Abnormal pap smear history (result and treatment) Y / N

Current form of birth control _____
Sterilization procedure performed/type _____
History of complications with birth control Y / N

History of: (include when, where and result)
Bone density _____
Blood cholesterol _____
Blood sugar _____
Stool for blood _____
Do you do breast self exams Y / N

Total number of:
Times you have been pregnant _____
Living children _____
Stillbirth (s) _____
Miscarriage (s) _____
Abortion (s) _____
C/section (s) _____ Vaginal _____
Premature _____ Ectopic _____

Pregnancies: (Date, type of delivery, sex, weight)
1. _____
2. _____
3. _____
4. _____
5. _____

Smoker: Never / Current / Former
If yes, how much/how often _____
How soon after waking do you smoke _____
Are you thinking/planning to quit Y / N

Do you use alcohol Y / N
Type, how often, last use _____

Do you use recreation/street drugs Y / N
Type, how often, last use _____

Are any recent events in your life causing you additional stress _____

Do you now, or have you ever, experienced any signs or feelings of depression _____

Are you now, or have you ever, been in a relationship which you have been emotionally, mentally, and/or physically hurt, abused, or threatened by anyone _____