



Annual Questionnaire

MRN#:

Patient Phone Numbers: (home & mobile)

Patient Name: _____

DOB: _____

Age: _____

Date: _____

REASON FOR YOUR VISIT TODAY?

CURRENT MEDS AND DOSE:

None

HERBAL SUPPLEMENTS/ OVER THE COUNTER MEDS:

None

Last Colonoscopy: _____

Last Mammogram: _____

Last Osteoporosis Screen: _____

Last Cholesterol Screening: _____

Last PAP Smear: _____

ALLERGIES:

None

Do you have an allergy to LATEX? No Yes

MEDICAL HISTORY:

None

High Blood Pressure

Thyroid Disease

Heart Disease

Arthritis

Infertility

GI Disease _____

Kidney Stones

High Cholesterol

Diabetes

GERD

Endometriosis

Depression/Anxiety/OCD/ADHD

Blood Clots (legs/lungs)

Gestational Diabetes

Asthma

Mitral Valve Prolapse

Abnormal PAP Smears/Dysplasia

STD _____

Osteoporosis/Osteopenia

Obesity

Other: _____

SURGICAL HISTORY:

None

PLEASE PROVIDE YEAR OF SURGERY IF POSSIBLE

Wisdom Teeth

Tonsillectomy

Thyroid

Breast Biopsy /Lumpectomy

Breast Mastectomy

Colonoscopy/Endoscopy

Heart Surgery

Bladder Surgery

Gall Bladder removed

Appendectomy

Hysterectomy (uterus only)

Ovaries removed

Cesarean Section

Laparoscopy

Hysteroscopy

Tubal Ligation/Essure

D&C / D&E

LEEP / CONE

Joint/Bone _____

Novasure/HTA/Thermachoice

Other: _____

Have you ever had a blood transfusion?

Yes No

OBSTETRICAL HISTORY:

None

Pregnancy Complications (please explain):

Number Pregnancies: _____ Number Vaginal Deliveries _____

Number Living Children _____ Number C/Sections _____

Number Miscarriages: _____ Number Adopted Children: _____

GYNECOLOGIC REVIEW OF SYMPTOMS:

Age at first period _____

First day of Last Period _____

Period Flow lasts _____ days

No. of days from the start of one period to the start of the next period (Cycle length):

_____ days

Current Contraception: None

Pills Patch Tubal Essure

Mirena/Paragard Nuvaring Depo

Condom Vasectomy Implanon

None

PMS

Painful periods

Heavy Periods

Spotting between periods

Pain w/ Intercourse

Low Libido

PLEASE TURN PAPER OVER FOR ADDITIONAL QUESTIONS. THANK YOU

PRIMARY CARE PHYSICIAN: _____

OTHER PHYSICIAN(S): _____

SOCIAL HISTORY:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Domestic Partner				
Tobacco Use:	<input type="checkbox"/> No <input type="checkbox"/> Yes	AMOUNT _____	/ HOW LONG USED? _____	QUIT DATE: _____	
Alcohol Use:	<input type="checkbox"/> No <input type="checkbox"/> Yes	HOW MANY DRINKS / WEEK _____			
Drugs Use:	<input type="checkbox"/> No <input type="checkbox"/> Yes	TYPE _____	TIMES/ WEEK _____		
Domestic Violence:	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Mental <input type="checkbox"/> Physical <input type="checkbox"/> Sexual			
Sunscreen Use:	<input type="checkbox"/> No <input type="checkbox"/> Yes	(SPF 15 or better is recommended)			
Seat Belt Use:	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Sexual Preference	<input type="checkbox"/> Male <input type="checkbox"/> Female				
Reg. Exercise:	<input type="checkbox"/> No <input type="checkbox"/> Yes	Type _____			
Occupation: _____	Do you have an Advanced Directive (Living Will)? <input type="checkbox"/> Yes <input type="checkbox"/> No				
FAMILY HISTORY :	<input type="checkbox"/> None	PLEASE INDICATE WHICH FAMILY MEMBER IS AFFECTED BY THE ILLNESS			
<input type="checkbox"/> Hypertension _____	<input type="checkbox"/> Birth Defects _____	<input type="checkbox"/> Blood Clots (legs/lungs) _____			
<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Stroke _____	<input type="checkbox"/> Alzheimer's/Parkinson's _____			
<input type="checkbox"/> Macular Degeneration _____	<input type="checkbox"/> Breast Cancer _____	<input type="checkbox"/> Colon Cancer _____			
<input type="checkbox"/> Heart Disease _____	<input type="checkbox"/> Uterine Cancer _____	<input type="checkbox"/> Other Cancer _____			
<input type="checkbox"/> Osteoporosis _____	<input type="checkbox"/> Ovarian Cancer _____	<input type="checkbox"/> Other Disease _____			
<input type="checkbox"/> High Cholesterol _____	<input type="checkbox"/> Cervical Cancer _____				
REVIEW OF SYSTEMS: Please check all that apply If you have none of these symptoms, please check <input type="checkbox"/> none					
General <input type="checkbox"/> none	<input type="checkbox"/> Weight loss	<input type="checkbox"/> Weight gain	<input type="checkbox"/> Fever	<input type="checkbox"/> Fatigue	
Eyes <input type="checkbox"/> none	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Glasses/contacts	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Blurry Vision	
ENT <input type="checkbox"/> none	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Sinusitis	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Headache	
Heart <input type="checkbox"/> none	<input type="checkbox"/> Irregular heart rate	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Shortness of Breath with exercise	<input type="checkbox"/> Shortness of Breath lying down	
Respiratory <input type="checkbox"/> none	<input type="checkbox"/> Cough	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Coughing up Blood	<input type="checkbox"/> Short of breath	<input type="checkbox"/> Pain w/Breathing
GI <input type="checkbox"/> none	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Constipation	<input type="checkbox"/> Bloody stool	<input type="checkbox"/> Black stool	<input type="checkbox"/> Excessive Gas
	<input type="checkbox"/> Nausea	<input type="checkbox"/> Leaking of Stool	<input type="checkbox"/> Irritable Bowel	<input type="checkbox"/> Vomiting	
Urinary <input type="checkbox"/> none	<input type="checkbox"/> Urgency	<input type="checkbox"/> Frequency	<input type="checkbox"/> urination at night	<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Pain with urination
	<input type="checkbox"/> Feeling bladder not emptying	<input type="checkbox"/> Leaking of urine	<input type="checkbox"/> Leaking of urine with coughing, laughing, sneezing		<input type="checkbox"/> Leaking of urine when urge to go
Muscle/Bone <input type="checkbox"/> none	<input type="checkbox"/> weakness	<input type="checkbox"/> Joint Pain	<input type="checkbox"/> Swelling	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Back Pain
Skin/breast <input type="checkbox"/> none	<input type="checkbox"/> Breast Pain	<input type="checkbox"/> Breast Discharge	<input type="checkbox"/> Rash	<input type="checkbox"/> Masses	<input type="checkbox"/> Skin Ulcers
Neurologic <input type="checkbox"/> none	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Seizures	<input type="checkbox"/> Trouble walking	<input type="checkbox"/> Numbness	<input type="checkbox"/> Headaches
Psychiatric <input type="checkbox"/> none	<input type="checkbox"/> Depression	<input type="checkbox"/> Crying	<input type="checkbox"/> Anxiety	<input type="checkbox"/> ADD / ADHD	
Endocrine <input type="checkbox"/> none	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hypothyroid	<input type="checkbox"/> Hyperthyroid	<input type="checkbox"/> hot flashes	<input type="checkbox"/> night sweats
Blood <input type="checkbox"/> none	<input type="checkbox"/> Bruises	<input type="checkbox"/> Unusual Bleeding	<input type="checkbox"/> Enlarged nodes		
When was your last immunization for:	Rubella Date _____	Tetanus Date _____	Pneumococcal (Pneumonia) Date _____	Hepatitis B Date _____	HPV Date _____

Patient Signature: _____

Date: ____/____/____

Provider Signature: _____

Date: ____/____/____