WOMEN'S & FAMILY HEALTH SPECIALISTS

Female Patient Health Questionnaire

Name_____ Age_____ Date_____

Medications_____

Allergies_____ Birth control method_____

Hospitalizations or Surgeries:

Date:	Surgery or reason for hospitalization:

Menstrual history
First day of last period_____
How many days does your period last?_____
Days from the start of one period until the next_____
Age period began_____ Age period ended_____

Pregnancy history
Number of pregnancies_____
Dates of pregnancies_____
Number of miscarriages_____
Number of abortions_____

Date of: last pap smear_____ last mammogram_____ last bone density test_____

Family history: Please indicate whether immediate relatives (parents, children, grandparents, aunts/uncles) have had any of the following:

Breast cancer_____
Ovarian cancer_____
Cervical cancer_____
Uterine cancer_____
Skin cancer_____
Colon cancer_____
Other cancer_____

High cholesterol_____
High blood pressure_____
Heart attack_____
Aneurysms_____
Stroke_____
Osteoporosis_____

Alzheimer's disease_____
Depression_____
Anxiety_____
Thyroid disease_____
Alchoholism_____
Diabetes_____

Social History: I live with_____ Marital status_____ Occupation_____

Do you smoke?_____ Packs per day_____ Do you drink?_____ Drinks per week_____ Do you use drugs?_____

Health problems or concerns. Mark "C" for current problems and "X" for past problems.

General
____ Cancer
____ Anemia
____ Blood clot in lungs or leg
____ Eating disorder
____ Unusual fatigue
____ Abnormal thirst
____ Sleeping problems
____ Skin trouble
____ Back pain

Neurological
____ Frequent headaches
____ Fainting spells
____ Seizures
____ Dizzy spells
____ Depression or anxiety

Neck
____ Goiter
____ Lump
____ Pain or stiffness

Heart
____ High blood pressure
____ Heart murmur
____ Heart attack/problems
____ Stroke
____ Shortness of breath
____ Night sweats
____ Chest pain or pressure
____ Palpitation or fluttering
____ Swollen ankles

Lungs
____ Asthma
____ Pneumonia
____ Chronic cough

Breast
____ Lump
____ Discharge
____ Pain

Intestinal
____ Ulcers
____ Bowel problems
____ Hepatitis
____ Gallbladder problems
____ Loss of appetite
____ Nausea or vomiting
____ Vomiting of blood
____ Pain in abdomen
____ Constipation
____ Diarrhea
____ Blood in stools
____ Black, tarry stools

Pelvic and genital
____ Endometriosis
____ Fibroids
____ Chlamydia or gonorrhea
____ Herpes
____ Abnormal pap smear
____ Pelvic pain
____ Irregular periods
____ Painful periods
____ Hot Flashes
____ Vaginal discharge
____ Vaginal irritation

Urinary
____ Kidney infections/stones
____ Bladder infections
____ Frequent urination
____ Pain with urination
____ Urine leakage
____ Blood in urine

Endocrine
____ Thyroid disease
____ Diabetes
____ Osteoporosis

Extremities
____ Arthritis, joint pain
____ Varicose veins
____ Broken bones

Any other illnesses or symptoms:

Do you have any special problems or concerns today that are not listed above?_____

Thank you for taking the time to complete this questionnaire. It will allow us to more completely address your needs and concerns.