MR#:

Name of Patient:

Date of Birth:

Place Label Here

UNIVERSITY OF CALIFORNIA, DAVIS
MEDICAL CENTER
SACRAMENTO, CALIFORNIA

PATIENT QUESTIONNAIRE

TODAY'S DATE: _____

Name: Date of Birth: Age:

Primary Care Physician:

Please state in your own words the reason for today's visit, (ie: what are your main concerns):

MEDICAL HISTORY

(Mark (x) if you have any of these conditions)

- ☐ Heart Disease
  - ☐ Congestive Heart Failure
  - ☐ Heart Attack
  - ☐ Angina
  - ☐ Heart Valve Disease
  - ☐ Heart Murmur
  - ☐ Other _____
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Blood Clots
- ☐ Diabetes
- ☐ Lung Disease
  - ☐ Asthma
  - ☐ Emphysema (COPD)
  - ☐ Other _____
- ☐ Lupus
- ☐ Kidney disease/problems
  - What Kind? _____
- ☐ Liver Disease
  - What Kind? _____
- ☐ Thyroid Disease/problems
  - What Kind? _____
- ☐ Cancer
  - What Kind? _____
- ☐ Seizures
- ☐ Migraines
- ☐ Alcoholism
- ☐ Drug Addiction
- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Chronic Fatigue Syndrome
- ☐ Fibromyalgia
- ☐ Osteoporosis/Osteopenia
- ☐ Arthritis
- ☐ Low Back Injury
- ☐ HIV/AIDS
- ☐ Irritable Bowel Syndrome
- ☐ Diverticulitis/Diverticulosis
- ☐ Esophageal Reflux/Stomach Ulcer
- ☐ Hemorrhoids
- ☐ Glaucoma
- ☐ Allergic to Latex
- ☐ Other Medical Problems: _____
- ☐ Drug allergies/reactions: _____

SURGICAL HISTORY

Please list all previous surgeries

SURGERY	DATE	SURGERY	DATE

GYNECOLOGICAL HISTORY

Number of pregnancies:	Date of last:	Number of vaginal deliveries:
Number of miscarriages:	Pregnancy ended:	Number of forceps/vacuum deliveries:
Number of abortions:		Number of cesarean deliveries:
Are you breastfeeding?	☐ No ☐ Yes	Number of children:

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PATIENT QUESTIONNAIRE

MENSTRUAL HISTORY

For women who STILL HAVE PERIODS

How old were you when you started your period?

First day of last period: Frequency of periods:

Length of each period: Describe bleeding: ☐ Heavy ☐ Medium ☐ Light

Are your periods painful? ☐ No ☐ Yes

Are you bleeding or spotting between periods? ☐ No ☐ Yes

Are you having any changes in your periods? ☐ No ☐ Yes

If 'yes', describe:

Current birth control method: How long have you used this method? _____ years

Do you have any problems with this method? ☐ No ☐ Yes If 'yes', describe:

Are you planning to get pregnant in the next year? ☐ No ☐ Yes

For women who STOPPED HAVING PERIODS

Have you had a hysterectomy (removal of uterus)? ☐ No ☐ Yes

If yes, reason for hysterectomy:

Have you had removal of ovaries? ☐ No ☐ Yes If yes, ☐ One ☐ Both

At what age did you stop having periods?

Have you taken hormone therapy? ☐ No ☐ Yes, in the past ☐ I currently take hormone therapy

GYNECOLOGICAL PROBLEMS

Have you ever had or do you now have any of the following:

Problem	Date(s) of problem or when problem began	Problem	Date(s) of problem or when problem began
☐ Uterus/ Cervix/ Ovary cancer		☐ Ovarian cysts/masses *(Not cancer)*	
☐ Abnormal pap smear		☐ Fibroids of uterus	
☐ Recurrent vaginal infections		☐ Endometriosis	
☐ Urinary incontinence		☐ Sexually transmitted infections	
☐ Urinary urgency/frequency *(not with a bladder infection)*		What Type?	

☐ Other gynecological problems?

Did your mother take DES when she was pregnant with you? ☐ No ☐ Yes ☐ Don't Know

Do you douche or use other "vaginal hygiene products"? ☐ No ☐ Yes

Do you think you might have been exposed to any sexually transmitted infections since your last gynecological exam? ☐ No ☐ Yes

Which statement describes your current sexual activity:

☐ I am not sexually active by choice

☐ I am not sexually active because my partner is unable

☐ I am not sexually active because I do not have a partner For how long?

☐ I am sexually active with one partner For how long? ☐ Male ☐ Female

☐ I am sexually active with more than one partner How many? ☐ Male ☐ Female ☐ Both

Do you have any sexual problems you would like to discuss? ☐ No ☐ Yes

If 'yes', what?

MR#: ☐☐☐☐☐☐☐☐

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PATIENT QUESTIONNAIRE

FAMILY HISTORY

Indicate which (if any) of your family members have had the following:

	Mother	Father	Any Sister	Any Brother	Mother's Mother	Mother's Father	Father's Mother	Father's Father
Breast Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Uterus/Ovary Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐
Psychiatric Problems	☐	☐	☐	☐	☐	☐	☐	☐
Stroke/Blood Clots	☐	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐

SOCIAL HISTORY/HABITS

What is your occupation?

How many hours of physical exercise (for recreation or fitness) do you do per week? _____Hours What type of exercise?

Do you currently smoke? ☐ No ☐ Yes If yes, how much? How Long?

If 'no', have you ever smoked? ☐ No ☐ Yes If yes, how much per week?

Do you currently drink alcohol? ☐ No ☐ Yes If yes, how much per week? How Long?

Have you ever used recreational drugs or had a prescription drug problem?
☐ No
☐ Yes, in the past: What drug? When did you quit?
☐ Yes, I currently use: What drug?

Martial Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ In a committed relationship

With whom do you live?

Have you ever been physically or sexually abused? ☐ No ☐ Yes

PREVENTION/SCREENING

Have you had any of these screening tests?

TYPE	DATE OF LAST TEST	RESULTS
Pap		☐ Always Normal ☐ Abnormal When?
Mammogram		☐ Always Normal ☐ Abnormal When?
Colonoscopy (if over 50)		
Bone density *(DEXA)* (If over 60)		

Have you had any of these vaccinations?

TYPE	DATE OF LAST Vaccine	RESULTS
Gardasil or Cervarix (HPV Vaccine)		Did you receive all three? ☐ No ☐ Yes
T-dap		
Flu		

REVIEW OF SYMPTOMS

In the last 3 months have you had (mark (x) all that apply

General Health:

Do you think your general health is: ☐ Excellent ☐ Good ☐ Fair ☐ Bad

Easily fatigued: ☐ No ☐ Yes

Weight lost in last year – how much? Lbs Weight gain in last year – how much? Lbs

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REVIEW OF SYMPTOMS (Continued)
In the last 3 months have you had (mark (x) all that apply

Menopause Symptoms:
- ☐ Hot Flashes How often? _____
- ☐ Vaginal Dryness ☐ Mood swings ☐ Trouble sleeping

Gastrointestinal Tract:
- ☐ Nausea or Vomiting ☐ Diarrhea ☐ Bloody or Black BM's ☐ Bleeding from rectum
- ☐ Constipation ☐ Intolerance to foods ☐ Heartburn

Hematological System:
- ☐ Anemia ☐ Easy bruising

Cardiovascular System:
- ☐ Chest pain with exercise or excitement ☐ Chest pain at rest ☐ Palpitations
- ☐ Swelling in legs or feet ☐ Can't lie flat to sleep ☐ Rapid and/or irregular heart beat
- ☐ Wake-up at night with shortness of breath

Pulmonary System:
- ☐ Shortness of breath without exercise ☐ Cough/Coughing up anything ☐ Wheezing in chest

Genitourinary System:
- ☐ Bleeding after intercourse ☐ Blood in urine ☐ Loss of interest in sex
- ☐ Exposure to sexually transmitted infection ☐ Vaginal itching ☐ Vaginal discharge

Neurological Systems:
- ☐ Dizziness ☐ Headaches ☐ Fainting spells/loss of consciousness
- ☐ Numbness or tingling in hands/feet ☐ Problems with memory ☐ Weakness in legs/arms

Musculoskeletal System:
- ☐ Painful Joints ☐ Swollen Joints ☐ Back Pain ☐ Need assistance to walk (eg: Cane)

Mental Health System:
- ☐ Depression ☐ Anxiety ☐ Any other mental health symptoms

Allergic/Immunologic:
- ☐ Coughing/sneezing ☐ Sinus pain/congestion

Breast/Skin:
- ☐ Breast lump(s) ☐ Nipple discharge ☐ New skin lesion
- ☐ Breast pain ☐ Change in moles ☐ Skin Rash

Endocrine:
- ☐ Feeling cold ☐ Feeling hot

Eye:
- ☐ Blurry Vision ☐ Dry eyes

Ears/Nose/Throat:
- ☐ Hard of hearing ☐ Wear hearing aids ☐ Dry mouth

How tall are you? Feet Inches

Reviewed by: _____, MD _____ _____
Signature Printed Name Date

Completed by: _____ _____
Patient Signature Date