ANNUAL HEALTH QUESTIONNAIRE UPDATE

Dear Patient: **Thank you** for taking the time to fill this form out. None of this confidential information will be released without your consent.

Name_____ Birthdate_____ Age_____ Date_____

First day of your last period_____

Allergies (antibiotics, metals, novacaine, iodine, etc.)_____

Current medications: (Include vitamins, herbs, birth control pills, Calcium, sleeping pills)

_____

Medical Illnesses:_____ Family physician:_____
Surgery in past year: _____ Specialists:_____

Immediate Family History (*please indicate family member*)

High blood pressure_____ Alcoholism_____ Osteoporosis_____
High cholesterol_____ Diabetes_____ Thyroid trouble_____
Heart attack_____ Stroke_____ Uterine fibroids_____
Cancer (Type)_____ Mental problems/Depression_____

Social History

Present relationship: Single____ Divorce____ Widow____ Separated____ Married for_____years

1. Do you smoke cigarettes? How many per day?_____
2. Do you drink alcohol ? How much per week?_____
3. Do you use recreational drugs? What type and how often?_____
4. Do you exercise regularly? What type & how often?_____
5. Are you on a special diet?_____
6. Are you seeing a counselor? Who?_____
7. Have you been hit, kicked, punched or otherwise hurt by someone in the past year?_____
8. Do you protect your skin from the sun?_____

Menstrual History

9. Do you menstruate? If no, stopped at age _____.
10. Are your periods regular?_____ Flow lasts _____ days.
11. How many days from the start of one period to the start of the next? _____days.
12. Are you having any signs of menopause (hot flashes, night sweats, moodiness, dryness, insomnia)?

_____

Contraceptive History

13. Are you currently using a birth control method? What?_____
14. Do you currently need a means to prevent pregnancy?_____

Sexuality History

15. Are you sexual with anyone? _____male _____female _____both male/female
16. Have you had any new sexual partners in the last year?_____
17. Do you have questions or concerns about sex, sexuality or relationships? (disinterest in sex, infrequent or no orgasm, vaginal dryness?)_____

Do you have any of the following symptoms?

Breast	**Abdominal**	**Urinary**	**Mental**
__monthly tenderness	__nausea or vomiting	__blood in urine	__trouble sleeping
__cysts or lumps	__constipation	__bladder infections	__nervousness/worry
__nipple discharge	__bloody stools	__frequent urination	__excessive fatigue
__would like to review breast self-exam	__diarrhea	__urgency of urination	__depression
	__change in weight	__lose urine w/coughing or sneezing	__worsening PMS
			__crying