MERIDIAN WOMEN'S HEALTH

PATIENT HEALTH QUESTIONNAIRE - UPDATE

Name _____
(please print)

Date _____ Age _____

Problems to discuss today _____

Operations / Hospitalizations: Anything new since your last visit? _____

Current Medications/Vitamins _____

Allergies to Medications: Anything New? _____

Family History: Changes in the health of father, mother, brother, sisters, children _____

First day of last menstrual period _____
Date of last mammogram _____
Date of last cholesterol screening _____
Date of Tdap vaccination _____

Date of last Pap smear _____
History of blood transfusion? _____
Date of last colonoscopy _____
Date of HPV vaccination_____series complete Y N

Are your periods regular? _____
Are you sexually active? _____
Birth control method currently used: _____
If menopausal, are you on hormone replacement? _____ Hormones used: _____
New sexual partner? _____
Do you wish to be checked for sexually transmitted diseases? _____
Do you feel safe at home? _____
Do you smoke? If so, how much? _____
Do you drink alcohol? If so, how much? _____
Have you ever felt the need to cut down? _____
Have you changed your occupation? _____
What kind of exercise are you doing? _____

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING:

Unexplained weight gain or loss …	yes	no	Abdominal pain	yes	no
Bleeding or bruising tendency …….	yes	no	Sexual difficulty	yes	no
Hay fever	yes	no	Breast lump	yes	no
High blood pressure	yes	no	Frequent or recurring headaches	yes	no
Asthma or wheezing	yes	no	Depression/Anxiety/Panic ……..	yes	no

Other Concerns: _____

Physician's Initials: _____
Date: _____