MERIDIAN WOMEN'S HEALTH

NEW PATIENT HEALTH QUESTIONNAIRE

Name ______________________________
(please print)
Date __________________ Age: _____

Problems to discuss today ____

MEDICAL HISTORY

Circle any past medical problems:

High blood pressure
Tuberculosis
Sickle cell trait
Kidney infections
Indigestion
Diabetes
Asthma
Anemia
Depression
Hepatitis
Heart murmur
Pneumonia
Glaucoma
Headache
Diverticulosis
Angina
Bronchitis
Cancer
Arthritis
Ulcers
Heart attack
Thyroid disease
Osteoporosis
Seizures

Any other significant medical problems: ____
____

Previous surgeries (include dates) ____
____

Current Medications/Vitamins/Over the counter meds or herbs ____________________________
____

Allergies to medications ____
____

Date of last cholesterol screening ___________
History of blood transfusion? ___________
Date of Tdap Vaccination ___________
Date of last Colonoscopy __________________ ____________
Date of HPV Vaccination________Series complete: Y N

GYNECOLOGICAL HISTORY

\# of pregnancies _____
\# of children _____
First day of last period _____
Period occurs every _____ days
Regular? ____
Period lasts _____ days
Age at 1st period _____
Age at menopause _____
Date of last pap smear __________________
Method of birth control currently used ____________________
Date of last mammogram ____________
If menopausal, are you on hormone replacement? _____
Hormones used __________________
Are you sexually active? _____
New sexual partner? __________________
Do you wish to be checked for sexually transmitted diseases? _____
Do you feel safe at home? ____________

Circle GYN problems you have had in the past:

Endometriosis
Gonorrhea
Ovarian cysts
Infertility
Chlamydia
Abnormal Pap
Fibroids
Breast problems
Pelvic Inflammatory Disease
Genital warts
Herpes

PATIENT SOCIAL HISTORY

Marital Status: Single ___ Married ___ Separated ___ Divorced ___ Widowed ___ Partner ___
Current Occupation ____
Spouse (name, age, medical problems) ______________________________________
Children (names, ages, medical problems) ______________________________________
____

Use of Alcohol: Drinks/week _____ Quit when _____ Have you ever felt the need to cut down? ______
Use of Caffeine, Cups per Day: Coffee _____ Soda _____ Tea _____
Use of Tobacco: Never _____ Previously, but quit _____ Current Packs/Day _____
Use of Drugs: Never _____ Previously, but quit _____ Type / Frequency ________________________
Exercise: Never _____ Rarely _____ Weekly _____ Daily _____ Type of Exercise ____________

FAMILY MEDICAL HISTORY:

Do you know of any blood relative who has or had: (indicate relationship)

Breast Cancer ____________________________
Ovarian Cancer ____________________________
Colon Cancer ____________________________
Diabetes ____________________________
Osteoporosis ____________________________
Bleeding Tendency ________________________
Heart Disease ________________________
High Blood Pressure ________________________
Mental Illness ________________________
TB ________________________

ADDITIONAL QUESTIONS ON BACK OF FORM