New Patient Intake <40yrs old

WOMEN'S CONTRACEPTIVE QUESTIONNAIRE

DATE

Formedic

NAME | MARITAL STATUS S M W D SEP | DATE OF BIRTH

SCHOOL / UNIVERSITY | OCCUPATION / EMPLOYER | REFERRED BY:

REASON FOR VISIT -

PAST MEDICAL & FAMILY HISTORY - *PLEASE CHECK (✓) IF YOU (PERS) OR ANY BLOOD RELATIVE (FAM) HAD ANY OF THE FOLLOWING CONDITIONS*

	PERS	FAM
1. WT LOSS-GAIN	☐	
2. HEADACHES / MIGRAINE	☐	
3. HEART DISEASE ☐ VALVULAR DIS ☐ RHEUMATIC DIS ☐	☐	☐
4. HIGH BLOOD PRESSURE	☐	☐
5. HIGH CHOLESTEROL	☐	☐
6. RESPIRATORY (LUNG) DISEASE	☐	☐
7. BREAST DISEASE	☐	☐
8. JAUNDICE / HEPATITIS	☐	☐
9. HIATAL HERNIA (REFLUX)	☐	☐
10. PEPTIC ULCER (STOMACH)	☐	☐
11. BOWEL DISEASE	☐	☐
12. KIDNEY DISEASE	☐	☐

	PERS	FAM
13. URINARY INFECTIONS	☐	☐
14. BLOOD TRANSFUSIONS	☐	
15. ANEMIA / BLOOD DISORDER	☐	
16. ACNE-COMPLEXION PROBLEM	☐	☐
SKIN DISEASE (OTHER)	☐	☐
17. DIABETES	☐	☐
18. THYROID DISEASE	☐	☐
19. CANCER (TYPE)	☐	☐
20. EPILEPSY / SEIZURES	☐	☐
21. ARTHRITIS - JOINT PAIN	☐	☐
22. ANXIETY / DEPRESSION	☐	☐
23. SLEEP PROBLEMS	☐	☐

HOSPITAL ADMISSIONS - *LIST THOSE OPERATIONS & SERIOUS ILLNESSES WHICH REQUIRED HOSPITALIZATION (EXCLUDING PREGNANCY)*

YEAR	REASON FOR ADMISSION / HOSPITAL	YEAR	REASON FOR ADMISSION / HOSPITAL

MEDICATIONS - *LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (DOSAGE - FREQUENCY) - INCLUDE OVER THE COUNTER DRUGS*

			DRUG ALLERGIES

OBSTETRICAL HISTORY *Number of* PREGNANCIES | PREMATURE BABIES | MISCARRIAGES | ABORTIONS | LIVING CHILDREN

MENSTRUAL HISTORY AGE AT FIRST PERIOD? _____ IF MENSTRUATING - DATE OF LAST PERIOD (1st day)?_____

PERIODS ARE ☐ REGULAR ☐ SOMEWHAT IRREGULAR ☐ COMPLETELY IRREGULAR

PERIOD INTERVAL (1st day to 1st day) ***Number of days?*** ____ DURATION OF BLEEDING? FROM _____ TO _____ DAYS

BLEEDING (SPOTTING) IN BETWEEN PERIODS? Y N

WITH YOUR PERIODS - DO YOU HAVE? - ☐ PAIN ☐ CRAMPS ☐ BLOATING

ANY PREMENSTRUAL SYMPTOMS - eg.: *IRRITABILITY, DEPRESSION, ANXIETY, BREAST PAIN?* Y N

TIME LOST FROM SCHOOL / WORK BECAUSE OF PERIODS? Y N

BIRTH CONTROL CURRENT METHOD | HOW LONG? | IF PILL - BRAND? | PAST METHODS

COMMENTS / PROBLEMS

SEXUAL HISTORY ARE YOU SEXUALLY ACTIVE? Y N IS INTERCOURSE SATISFACTORY? Y N PAIN / BLEEDING WITH INTERCOURSE? Y N

WISH TO DISCUSS? Y N

PELVIC EXAM DATE OF LAST EXAM **PAP TEST** DATE OF LAST TEST ☐ NORMAL ☐ ABNORMAL

INFECTIONS AT PRESENT - ANY ABNORMAL VAGINAL DISCHARGE? Y N

History of ☐ YEAST INFECTIONS ☐ TRICHOMONAS ☐ URINARY INFECTIONS ☐ CHLAMYDIA ☐ GONORRHEA ☐ HERPES ☐ BACTERIAL INFECTION

BREASTS ***DO YOU*** - ROUTINELY CHECK YOUR BREASTS? Y N HAVE ANY NIPPLE DISCHARGE? Y N

HAVE ANY - ☐ PAINFUL ☐ TENDER OR ☐ LUMPY BREASTS? HAVE ANY OTHER CONCERNS? Y N

SOCIAL HISTORY **SMOKING** CIG / DAY | # YEARS | **ALCOHOL** OZ / WK | **COFFEE** CUPS / DAY | **STREET DRUGS**

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