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**A PROFESSIONAL MEDICAL CORPORATION**
**INTERNAL MEDICINE**
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# FEMALE PATIENT QUESTIONNAIRE

Last Name: ________________________________________ First Name ________________________________________

CURRENT AGE: _______________________ Approx. Height: ____________________ Approx. Weight ______________

Date of Visit/Appointment: _________________________________________________________

Hello! I look forward to meeting you in our office. In order to help you get the best medical service and respect your valued time, it would be most helpful if you fill this form out prior to your arrival. This will allow me to formulate a diagnostic plan and guide your health care more appropriately. If you need more space, please feel to write on additional blank pieces of paper. Please be aware that all information you share with me is strictly CONFIDENTIAL.

Please list the names of medications you are allergic to and their respective symptoms:

1. ____________________________________________________________________________________________
2. ____________________________________________________________________________________________
3. ____________________________________________________________________________________________
4. ____________________________________________________________________________________________

If you have particular issues you would like to discuss on your initial visit, please describe the problem below. When did it start? Are there any associated symptoms? Have you tried to address the problem with any over the counter remedies or have other doctors addressed this in the past? What tests have you had, if any, to evaluate this problem?

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**PAST MEDICAL HISTORY AND PROCEDURES:**

If you have any of these diagnoses or procedures please document when you were diagnosed. If you have other diagnosis not noted in the numbered section please document below.

1. Hypertension________________________________
2. Blood Transfustion________________________________
3. Sleep Apnea________________________________
4. Elevated Cholesterol________________________________
5. Diabetes ________________________________
6. Heart Disease ________________________________
7. Heart Attack ________________________________
8. Heart Failure ________________________________
9. Stroke ________________________________
10. Transient Ischemic Attack (TIA)________________________________
11. Seizure Disorder ________________________________
12. Asthma ________________________________
13. Pneumonia ________________________________
14. Emphysema ________________________________
15. Stomach Ulcers ________________________________
16. Under active thyroid ________________________________
17. Over active thyroid ________________________________
18. Migraines ________________________________
19. Osteoporosis ________________________________
20. Pacemaker Placement ________________________________
21. Blood Clots ________________________________
22. Arthritis ________________________________
23. Low Blood Counts ________________________________
24. Depression ________________________________
25. Anxiety Disorder ________________________________
26. Panic Attacks ________________________________
27. Cardiac Rhythm Abnormalities ________________________________
28. Hepatitis ________________________________
29. Heartburn ________________________________
30. Peripheral Artery Disease ________________________________
31. Angioplasty or Stenting of the Arteries of your heart ________________________________
32. Angioplasty or Stenting of the Arteries of your legs ________________________________
33. Cancer ________________________________
34. Blood Disorders ________________________________
35. Other Diagnosis not noted above, please document below:

    ________________________________________________
    ________________________________________________
    ________________________________________________
    ________________________________________________
    ________________________________________________
    ________________________________________________

**PAST SURGICAL HISTORY:**

Please list any surgeries you have had in your life and the year they were done:

________________________________________________
________________________________________________
________________________________________________

**MEDICATIONS:**

One each line, please list the name of a medication you take, along with the dose and the frequency of your use:

1. ______
2. ______
3. ______
4. ______
5. ______
6. ______
7. ______
8. ______
9. ______
10. ______
11. ______
12. ______
13. ______
14. ______
15. ______

**HEALTH MAINTENANCE:**

1. Have you ever had a colonoscopy? If so, when? If yes, what were the findings? ______
2. Have you ever had an endoscopy of your stomach? If so, when? If yes, what were the findings? ______
3. Have you ever had a stress test for your heart? If so, when? If yes, what were the results? ______
4. Have you ever had a mammogram? If so, when? If yes, what were the results? ______
5. Have you ever had a pap smear? If yes, when? If yes, what were the results? ______
6. Have you had an echocardiogram or ultrasound of your heart? If so when and what were the results?______
7. Have you ever had Bone Density Testing? If so when?______
8. Have you ever had a Tetanus shot? If so, when? ______
9. Have you ever had Pneumonia Vaccine? If so, when? ______
10. Have you ever had your Hepatitis A Vaccines? If so when?______
11. Have you ever had your Hepatitis B Vaccinatins? If so when?______
12. If you are over the age of 60 have you had your Shingles Vaccination? If so when?______
13. Have you had an H1N1 Vaccination? If so when?______
14. Have you had a Gardasil vaccination series? ______
15. Have you ever had Pneumonia Vaccine? If so, when? ______

**SOCIAL HISTORY**

What is your Marital Status?________________________________________
What is your profession? ________________________________________
Are you or have ever been sexually active? ______________________________
Do you sleep with women, men, or both? ______________________________
Are you currently smoking cigarettes? _______________________________
If you ever smoked, on average, how many cigarettes did you smoke and how many total years have you smoked?

How many glasses of alcohol do you drink in a week? _________________________
How many cups of coffee do you drink a day? ____________________________
Do you exercise regularly, and if so, what do you and how many minutes a day do you do the activity?

Do you smoke marijuana, and if so, how often and how many years? ____________________

In the past, have you used any recreational drugs, and if so, what were they and how often and for how long did you use them? ________________________________________

What kind of pets do you have at your residence, if any? ________________________

**FAMILY MEDICAL HISTORY:**

Please list the medical problems that the following relatives have had. Please list their current age. If they have passed away, please document this and their age at the time they passed away.

1. Mother________________________________________
2. Maternal Grandmother ____________________________________
3. Maternal Grandfather ____________________________________
4. Father ________________________________________
5. Paternal Grandmother ____________________________________
6. Paternal Grandfather ____________________________________
7. Brother ________________________________________
8. Brother ________________________________________
9. Brother ________________________________________
10. Sister ________________________________________
11. Sister ________________________________________
12. Sister ________________________________________
13. Aunts and Uncles ____________________________________

**REVIEW OF SYSTEMS: (*leave blank*)**