Women's Center
at Westover Hills

# PATIENT HEALTH QUESTIONNAIRE

## PLEASE PRINT WHEN COMPLETING THIS FORM

| | | | | |
|---|---|---|---|---|
| Today's date: | | | | |
| **PATIENT INFORMATION** | | | | |
| Patient's last name: First: Middle: | ❑ Mr. ❑ Mrs. | ❑ Miss ❑ Ms. | Marital status (circle one) Single / Mar / Div / Sep / Wid | |
| Reason for your visit with us today? | | | | |
| **MEDICATIONS AND ALLERGIES** | | | | |
| Current Medications (prescribed and over the counter): | | | | |
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| Medications Allergies with reaction: | | | | |
| Latex allergy? ❑ Yes ❑ No | | | | |
| **REPRODUCTIVE HISTORY** | | | | |
| First day of last menstrual period: | | | Age of first menstrual period: | |
| How often do you get your period? Every days | | | | |
| Regular or Irregular (circle one) | | | | |
| How many pads/tampons do you use on your heaviest day? | | | | |
| Any spotting/pain between periods? | | | | |
| Do you have pain with intercourse? | | | | |
| Are you in a monogamous relationship? | | | | |
| Is your primary relationship a (Female or Male)? | | | | |
| How many partners in your lifetime? | | | | |
| Current contraceptive method? | | | | |
| Have you ever had a sexually transmitted disease? Yes or No | | | | |
| If yes, please explain: Date: Treated: Yes or No Partner Treated: Yes or No | | | | |
| Date of last Pap Smear: History of abnormal Pas Smear? Yes or No | | | | |
| If yes, date of abnormal pap: Treatment required: | | | | |
| Date of last Mammogram: Do you do self-breast exams? Yes or No | | | | |
| Have you ever has a bone scan? Yes or No If yes, date: Findings: | | | | |

## OBSTETRICAL HISTORY

| Year | Vaginal or Cesarean | Weeks at Delivery | Length of Labor | Sex | Birth Weight | Complications |
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Any history of infertility? Yes or No

How many pregnancies? (Include – miscarriage and abortion):

## MEDICAL HISTORY

| | | | | | |
|---|---|---|---|---|---|
| | Anemia | | DVT / Blood Clots | | Liver Disease |
| | Arthritis | | Eating Disorder | | Migraines |
| | Asthma | | Heart Disease | | Osteoporosis |
| | Bleeding Problem | | High Blood Pressure | | Seasonal Allergies |
| | Breast Cancer | | High Cholesterol | | Stroke |
| | Diabetes | | Kidney Disease | | Thyroid Disease |

Please check all that apply.

## SURGICAL HISTORY / HOSPITALIZTION / BLOOD TRANSFUSIONS

| **Year** | **Surgery** |
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## FAMILY HISTORY- INDICATE IF AN IMMEDIATE FAMILY MEMBER HAS THE FOLLOWING (PARENTS, GRANDPARENTS, SIBLINGS)

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|---|---|
| Breast Cancer | High Cholesterol |
| Colon Cancer | Osteoporosis |
| Diabetes | Ovarian Cancer |
| Heart Disease | Stroke / DVT |

Please circle all that apply.

## PERSONAL HISTORY

Have you ever been hit, kicked, or punched by an intimate partner? Yes or No

If yes, is it currently happening? Yes or No

Have you ever been forced to have sex by an intimate partner? Yes or No

Do you smoke? Yes or No

How much alcohol do you drink each week?

Any history of recreational drug use (marijuana, cocaine, heroin, etc.)?

Medical Technologist Signature: Date: