Visalia Women's Specialty Medical Group, Inc.

Patient Health Questionnaire

Name _____

Date _____

Primary Care Physician _____

Referred by _____

Medications and dosages:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Medical History- Past and Present Medical Problems: Check all that apply

- ☐ Diabetes
- ☐ Hypertension
- ☐ High Cholesterol
- ☐ Asthma
- ☐ Thyroid Problems
- ☐ Kidney Problems
- ☐ Cancer
- ☐ Heart Problems/Murmurs
- ☐ Lung Disease/Tuberculosis
- ☐ Stomach or Intestinal Problems
- ☐ Freezing of the Cervix
- ☐ Leep of the Cervix
- ☐ Sexually Transmitted Diseases
- ☐ Anxiety
- ☐ Depression
- ☐ Other Psychiatric Problems
- ☐ Seizures
- ☐ Anemia
- ☐ HIV/AIDS
- ☐ Seasonal Allergies
- ☐ Latex Allergy
- ☐ Arthritis
- ☐ Collagen Vascular Disease
- ☐ Skin Disease
- ☐ Gastric Reflux
- ☐ Osteoporosis/Osteopenia
- ☐ Stroke
- ☐ Migraines/Headaches
- ☐ Deep Vein Thrombosis

Allergies/Bad Reactions to Medications:

_____

_____

Gynecologic History:

Last Menstrual Period _____

Periods are every _____ days, lasting for _____days with light, normal or heavy flow

Did you receive the 3 HPV vaccinations between ages 12 and 27? Yes No

Number of Pregnancies _____

Number of Deliveries _____

Number of Miscarriages/Terminations _____

Last Pap Smear _____

Abnormal Paps in the past? _____

Last Mammogram _____

Current Birth Control _____

Every had any Genetic Testing done ☐ Yes ☐ No Type _____

Surgical History: Check all that apply

☐ Appendectomy
☐ Tonsillectomy
☐ Gallbladder removal
☐ Cesarean Section
☐ Ectopic Pregnancy
☐ Tubal Ligation
☐ Laparoscopy
☐ Hysterectomy
☐ Other Gynecologic Surgery
☐ Stomach or Bowel Surgery
☐ Bladder Surgery
☐ Breast Surgery
☐ Bone or Joint Surgery
☐ Cosmetic Surgery
☐ Gastric Bypass
☐ Other Surgeries:

_____

_____

_____

Family History:

Does anyone in your family have the following?
(include parents, grandparents, siblings, children, aunts and uncles)

High Blood Pressure _____

Diabetes _____

Heart Disease _____

Ovarian Cancer _____

Breast Cancer _____

Colon Cancer _____

Social History:

Have you ever smoked? ☐ Yes ☐ No How many packs per day? _____

When did you quit? _____

Do you drink alcohol? ☐ Yes ☐ No How many drinks per week? _____

Do you use recreational drugs or medical marijuana? ☐ Yes ☐ No

Preventive Medicine:

Last Blood Work for diabetes, cholesterol, thyroid problems _____

Last Colonoscopy _____

Last Bone Density Test _____