Visalia Women's Specialty Medical Group, Inc.

Patient Health Questionnaire

Name _____

Date _____

Primary Care Physician _____

Referred by _____

Medications and dosages: **Reason for taking Medication:**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

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

- ☐ Diabetes
- ☐ Hypertension
- ☐ High Cholesterol
- ☐ Asthma
- ☐ Thyroid Problems ☐ Low ☐ High
- ☐ Kidney Problems, Type _____
- ☐ Cancer, Type _____
- ☐ Heart Problems/Murmurs, Type _____
- ☐ Lung Disease/Tuberculosis, Type _____
- ☐ Sexually Transmitted Diseases, Type _____
- ☐ Anxiety
- ☐ Depression
- ☐ Other Psychiatric Problems, Type _____
- ☐ Seizures
- ☐ Anemia in last year
- ☐ HIV/AIDS
- ☐ Seasonal Allergies
- ☐ Arthritis, Type _____
- ☐ Skin Disease, Type _____
- ☐ Gastric Reflux
- ☐ Osteoporosis ☐ Osteopenia
- ☐ Stroke
- ☐ Migraines/Headaches
- ☐ Deep Vein Thrombosis
- ☐ Other
- ☐ Stomach or Intestinal Problems, Type _____
- ☐ Collagen Vascular Disease, Type _____

Allergies/Bad Reactions to Medications: **Type of reaction:**

_____ _____

_____ _____

Latex Allergy ☐ Yes ☐ No

Gynecologic History:

Last Menstrual Period _____

☐ I have no periods

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 _____

Last Mammogram _____

What are you doing to prevent pregnancy?

- ☐ IUD, Type _____ Date: _____
- ☐ Arm Implant
- ☐ Pill, Patch, Ring, Shot
- ☐ Vasectomy, Tubal
- ☐ Withdrawal
- ☐ Condoms
- ☐ Trying to get Pregnant
- ☐ Not Preventing Pregnancy

Every had any Genetic Testing for cancer risk done ☐ Yes ☐ No Type _____

Surgical History: Check all that apply

- ☐ Appendectomy
- ☐ Tonsillectomy
- ☐ Gallbladder removal
- ☐ Cesarean Section, how many _____
- ☐ Ectopic Pregnancy
- ☐ Tubal Ligation
- ☐ Laparoscopy, for what _____
- ☐ Hysterectomy, with ovary removal ☐ Yes ☐ No
- ☐ Other Gynecologic Surgery, Type _____
- ☐ Stomach or Bowel Surgery, Type _____
- ☐ Freezing of Cervix, year _____
- ☐ Leep of Cervix, year _____
- ☐ Bladder Surgery, Type _____
- ☐ Breast Surgery, Type _____
- ☐ Bone or Joint Surgery, Type _____
- ☐ Cosmetic Surgery, Type _____
- ☐ Gastric Bypass _____
- ☐ Other Surgeries: _____

Family History:

Who in your family has the following? Include parents, grandparents, siblings, children, aunts and uncles and whether maternal (mother's) or paternal (father's) side of family.

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 Type _____

Preventive Medicine:

Last Blood Work for diabetes, cholesterol, thyroid problems _____

Last Colonoscopy _____ Any polyps ? ☐ Yes ☐ No When is your next colonoscopy due ? _____

Last Bone Density Test _____