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
- ☐ High Cholesterol
- ☐ Seizures
- ☐ HIV/AIDS
- ☐ Osteoporosis
- ☐ Gastric Reflux
- ☐ Migraines/Headaches
- ☐ Thyroid Problems ☐ Low ☐ High
- ☐ Anxiety
- ☐ Depression
- ☐ Other Psychiatric Problems, Type _____
- ☐ Kidney Problems, Type _____
- ☐ Cancer, Type _____
- ☐ Heart Problems/Murmurs, Type _____
- ☐ Lung Disease/Tuberculosis, Type _____
- ☐ Sexually Transmitted Diseases, Type _____
- ☐ Arthritis, Type _____
- ☐ Skin Disease, Type _____
- ☐ Stomach or Intestinal Problems, Type _____
- ☐ Collagen Vascular Disease, Type _____
- ☐ Other _____

- ☐ Hypertension
- ☐ Asthma
- ☐ Anemia in last year
- ☐ Seasonal Allergies
- ☐ Osteopenia
- ☐ Stroke
- ☐ Deep Vein Thrombosis

Latex Allergy ☐ Yes ☐ No

Allergies/Bad Reactions to Medications:

_____
_____

Type of reaction:

_____
_____

Gynecologic History:

Last Menstrual Period _____

☐ I have no periods

Periods are every _____ days, lasting for _____ days with light, normal or heavy flow (circle one)

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

Have you ever 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 _____