



New Patient Adult Female Medical Questionnaire

Name: _____
 S / M / D / W / P _____ Children Y / N _____
 Who makes medical decisions for you if you are not able to?
 Name _____ Relationship _____
 Occupation: _____
 Hobbies/Interests: _____
 Do you have a Living Will or Advanced Directives? Y / N
 If not are you interested in materials on how to make one? Y / N

What is the reason for your visit today? _____

Current & Past Medical Problems

Current Medications (name & dose)
 Please include vitamins, etc.

Allergies to medications, food or X-ray dye _____
 Pharmacy Name and Location _____

Past Surgical History, Operations, and Hospitalizations (include dates)

Have you had any Blood Transfusions? When?		Tetanus Shot (Date)	
Drink Alcohol x per week		Pneumonia Shot (Date)	
Smoke Packs per day Number of Years		Flu Shot (Date)	
Last Blood Work (Date)		Colonoscopy (Date)	
		Dexa Scan (Date)	



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Review Of Systems

(Check any you are currently experiencing or have significant history of)

Current	Past		Current	Past	
		Weight Loss			Nausea
		Weight Gain			Constipation
		Fever			Blood in Stool
		Chills			Diarrhea
		Rash			Frequent Urination
		Headaches			Painful Urination
		Eye Problems			Painful/Frequent Periods
		Allergies			Loss of Libido
		Ear Infection			Hair Loss
		Sinus Infections			Too Hot/Too Cold
		Sore Throat			Joint Pain
		Shortness of breath			Anxiety/Daily Worry
		Wheezing or Asthma			Depression
		Cough			Panic Attacks
		Chest Pain or Pressure			Obsessive/Compulsive
		Funny or Rapid Heartbeat			Mania
		High Blood Pressure			Considered/Attempted Suicide
		Difficulty Swallowing			Alcohol Abuse
		Indigestion/Heartburn			Drug Abuse
		Barrets Esophagus			Sleep disorder

Family History

	Living or Deceased	Age (Current or at time of death)	List All Medical Problems
Father			
Mother			
Siblings			

For Women Only:

_____ Name of Gynecologist _____ Date of Last Pap _____ History of Abnormal Paps _____ Date of Last Mammogram _____ Date of Last period	_____ # Pregnancies _____ # Births _____ # Miscarriages/Other _____ Current Contraception _____ Years of Post Menopausal HormoneUse
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Relatives with Breast or Ovarian Cancer _____
