

Do you have a medical advanced directive on file?

WILLOW CREEK WOMEN'S CLINIC

Today's Date _____

PATIENT QUESTIONNAIRE

Patient's Name _____

Birth Date _____

If this is your **1st visit** to WCWC please complete this form. If this is a **return visit**, please update sections 1&2 and complete sections 3, 4, 5 and 6

1. FAMILY HISTORY: (include natural parents, siblings, grandparents, aunts, uncles, and children.) Note age of onset if known.

Cancer _____ Diabetes _____

High Blood Pressure _____ Heart Disease _____

Stroke _____ Alcoholism _____

Other _____

2. SURGICAL AND MEDICAL HISTORY: Mark yes or no. Give dates if known.

Tonsils _____ Hysterectomy _____ Tubal Ligation _____

Appendix _____ Hemorrhoids _____ D & C _____

Gall Bladder _____ Blood Transfusion _____ Thyroid _____

Kidney _____ Diabetes _____ Heart _____

Hospitalizations _____ Asthma _____ HTN (high blood pressure) _____

Eating Disorder _____ Anxiety/Depression _____ Other (including surgeries) _____

Are you currently taking any medications? If so, please list:

Do you smoke? _____ Amount _____ Alcohol Use _____ Drug Use _____
(occasionally or list amount per day)

3. Are you on a special diet? Yes _____ No _____ Name of diet _____

4. ALLERGIES:

Drugs _____

Food: _____

Other: _____

5. SOCIAL HISTORY:

Do you exercise? (yes/no) _____ Do you take any calcium supplements? (yes/no) _____

Do you feel safe in your relationship with your partner? (yes/no) _____ Seatbelt Use? (yes/no) _____

6. MENSTRUAL HISTORY:

Age of first menstruation _____ Menopause: Yes ____ No ____ When _____

Number of days your period usually lasts _____

Number of days from 1st day of on period to the 1st day of the next _____

Number of pregnancies _____ Number of Children _____ Miscarriages _____

First day of last menstrual period (date) _____ Last pap smear (date) _____

Method of birth control _____

Have you had a tubal ligation, or has your husband had a vasectomy?

Yes _____ No _____ Unsure _____
 Abnormal pap smear in the past? If yes, when? _____

REVIEW OF SYSTEMS:

YES	NO	UNSURE		YES	NO	UNSURE	
_____	_____	_____	General	_____	_____	_____	GASTROINTESTINAL
_____	_____	_____	Recent weight change	_____	_____	_____	Heartburn
_____	_____	_____	Fever, chills, or night sweats	_____	_____	_____	Addominal pain
_____	_____	_____	Increase drinking or urinating	_____	_____	_____	Nausea or vomiting
_____	_____	_____	Lumps or masses	_____	_____	_____	Bloating or food intolerance
_____	_____	_____	Dizziness or lightheadedness	_____	_____	_____	Peptic ulcer disease
_____	_____	_____	Fainting	_____	_____	_____	Liver disease
_____	_____	_____	Headaches	_____	_____	_____	Jaundice
_____	_____	_____	Itching	_____	_____	_____	Galbladder disease
_____	_____	_____	Rashes or skin problems	_____	_____	_____	Diarrhea
_____	_____	_____	Thyroid disorder	_____	_____	_____	Constipation
_____	_____	_____	Cancer	_____	_____	_____	Black tarry stool
_____	_____	_____	Easy bruising or bleeding				
_____	_____	_____	Fatigue				GENITOURINARY
_____	_____	_____	Always hot or cold	_____	_____	_____	Do you get up at night to urinate?
			BREASTS	_____	_____	_____	Pain or burning with urination
_____	_____	_____	Lumps	_____	_____	_____	Difficulty starting or holding urine
_____	_____	_____	Tenderness	_____	_____	_____	Urinary or bladder infections
_____	_____	_____	Drainage from nipple	_____	_____	_____	Kidney or bladder stones
_____	_____	_____	Monthly breast self-exam	_____	_____	_____	Genital warts
			EYE,EAR,NOSE&THROAT	_____	_____	_____	Gonorrhea, Syphilis,or Chlamydia
_____	_____	_____	Eye pain	_____	_____	_____	Genital herpes
_____	_____	_____	Glaucoma	_____	_____	_____	Pain or other problems with intercourse
_____	_____	_____	Blurred or double vision	_____	_____	_____	Possibly pregnant
_____	_____	_____	Use glasses or contact lenses	_____	_____	_____	Change in menstrual pattern
_____	_____	_____	Loss of hearing	_____	_____	_____	Disabling menstrual cramps
_____	_____	_____	Ringling in ears	_____	_____	_____	Unusual vaginal discharge or bleeding

Drainage from ears
Trouble with nose or sinuses
Teeth or gum problems
Use dentures
Hoarseness
History of radiation therapy to head or neck

RESPIRATORY

Cough
Sputum(phlegm) production
Pneumonia or pleurisy
Shortness of breath w/activity
Wheezing or asthma
Pulmonary emboli (blood clot to the lung)

CARDIOVASCULAR

Palpitations
Chest pain
Heart disease
Rheumatic fever
Ankle swelling
Shortness of breath at night
Pain in legs with minimal activity (eg. walking 6-blocks or 2-flights of stairs)
Blood clots (thrombophlebitis)
Difficulty breathing when lying flat

Did your mother take "DES" (Diethylstilbesterol) when pregnant with you?
PMS (premenstrual syndrome)
Other(describe): _____

MUSCULOSKELETAL

Neck or back pain
Joint problems
Muscle weakness
Night cramps
Use a brace or splint

OTHER

Any other concerns you wish to discuss?

Please list your main concern for today's visit:

