Rosemary Delgado MD.

PATIENT QUESTIONNAIRE

NAME_____ DATE_____
AGE_____ FIRST DAY OF LAST MENSTRUAL PERIOD_____
MENSTRUAL FLOW [] HEAVY []REGULAR [] IRREGULAR [] PAINFUL
DAYS OF FLOW____ LENGTH OF CYCLES [] < 21 DAYS [] 24-31 DAYS [] >32 DAYS
[] PAIN/BLEEDING DURING OR AFTER INTERCOURSE
ARE YOU PREGNANT, OR DO YOU THINK YOU MAY BE PREGNANT?_____
ARE YOU NURSING?_____ DATE OF LAST PREGNANCY_____
WHAT METHOD OF BIRTH CONTROL DO YOU USE?_____
ARE YOU MENOPAUSAL?_____
DATE OF LAST PAP SMEAR_____ HISTORY OF ABNORMAL PAPS? YES/NO
DATE OF LAST MAMMOGRAM_____ HISTORY OF ABNORMAL MAMMOGRAMS? YES/NO
ANY FAMILY HISTORY OF BREAST CANCER?_____
TOTAL PREGNANCIES____ABORTIONS____MISCARRIAGES___BIRTHS_____
ANY ECTOPIC PREGNANCIES?_____
ARE YOU SEXUALLY ACTIVE?_____ MONOGAMOUS : YES/NO
NUMBER OF PARTNERS IN THE LAST YEAR?_____
DO YOU HAVE ANY QUESTIONS ABOUT YOUR SEXUALITY?_____
ANY SAFE SEX ISSUES?_____
ARE YOU CURRENTLY TAKING ANY MEDICATIONS?_____
_____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING ITEMS?

- ☐ LOCAL ANESTHISIA
- ☐ PENICILLIN
- ☐ SULFA DRUGS
- ☐ NARCOTICS (e.g. codeine)
- ☐ SEDATIVES
- ☐ IODINE
- ☐ ASPIRIN
- ☐ METALS (e.g. copper, nickel, etc.)
- ☐ LATEX
- ☐ ANY OTHER ALLERGIES_____.

HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGERIES OR SERIOUS ILLNESS?
_____
_____.

PLEASE COMPLETE THE OTHER SIDE OF THIS FORM

HABITS:

☐ ALCOHOL TYPE_____ AMOUNT_____ PER DAY/MONTH
☐ DRUG USE: TYPE_____
☐ SMOKE : PACK PER DAY_____ FOR HOW LONG?_____
☐ CAFFEINE: HOW MUCH PER DAY?_____
☐ EXERCISE: TYPE_____ HOW OFTEN?_____

DO **YOU** HAVE ANY OF THE FOLLOWING?

[]ABDOMINAL PAIN
[]ANEMIA
[]ANXIETY/DEPRESSION
[]ASTHMA
[]MENTAL ILLNESS
[]RHUEMATIC FEVER
[]SEXUAL DYSFUNCTION
[]PAINFUL URINATION
[]HEART MURMUR
[]PACEMAKER
[]HEPATITIS/JAUNDICE
[]MITRAL VALVE PROLAPSE
[]PNUEMONIA
[]STROKE
[]URINARY INCONTINENCE
[]VENEREAL DISEASE
[]TUBERCULOSIS
[]LIVER DISEASE
[]GLAUCOMA
[]CANCER
[]SEIZURES
[]FATIGUE
[]OTHER_____

[]ALLERGIES/HAYFEVER
[]SWOLLEN ANKLES
[]ARTHRITIS/RHUEMATISM
[]LOSS OF APPETITE
[]BLEEDING PROBLEMS
[]BLOOD CLOTS
[]DIZZINESS/FAINTING
[]FREQUENT HEADACHES
[]HEART ATTACK
[]HEART DISEASE
[]KIDNEY DISEASE
[]CHANGE IN BOWEL HABITS
[]CHEST PAIN
[]DIABETES
[]VARICOSE VEINS
[]WEIGHT LOSS
[]AIDS/HIV
[]BACK PAIN
[]OSTEOPOROSIS
[]SKIN DISEASE
[]THYROID DISEASE

DO YOU HAVE ANY **FAMILY HISTORY** OF THE FOLLOWING?

[]ALCOHOLISM	[]ASTHMA	[]BLEEDING DISORDERS
[]CANCER	[]DIABETES	[]HEART DISEASE
[]EPILEPSY	[]STROKE	[]HIGH BLOOD PRESSURE
[]MIGRAINES	[]KIDNEY DISEASE	[]THYROID DISEASE
[]MENTAL ILLNESS	[]OSTEOPOROSIS	[]BLOOD CLOTS