Patient Questionnaire

Name: _____ Date: _____

What is the reason for your visit? _____

Since your last examination, have you had any problems with:

	YES	NO
Your menstrual cycles?	☐	☐
Irregular Bleeding?	☐	☐
Cramps with your periods?	☐	☐
Abnormal vaginal discharge?	☐	☐
Pelvic/abdominal pain?	☐	☐
Breasts?	☐	☐
PMS?	☐	☐
Any urinary problems, burning, frequency, loss of urine?	☐	☐
Physical/mental/sexual abuse?	☐	☐
Since your last visit, have you had any:		
Medical Problems?	☐	☐
Sexual Problems?	☐	☐
Surgeries?	☐	☐
Change in family history?	☐	☐
Are you at increased risk for osteoporosis?		
Family history?	☐	☐
Menopause?	☐	☐
Loss of height?	☐	☐
History of steroid therapy?	☐	☐
Do you have any nutritional concerns?		
Weight gain/loss?	☐	☐
Cholesterol/Triglycerides?	☐	☐
Diabetes?	☐	☐

What prescription or over-the-counter medications do you take on a regular basis? _____

_____

	YES	NO	
Do you smoke?	☐	☐	How much? _____
Do you drink alcohol?	☐	☐	How much? _____
Do you get calcium in your diet?	☐	☐	How? _____
Do you do self breast exams?	☐	☐	
Have you found any problems?	☐	☐	

How often do you exercise? _____ How long? _____

What type of exercise? _____

Are there any problems or issues you would like to discuss? _____

_____

Patient Signature: _____