

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?	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Bleeding?	<input type="checkbox"/>	<input type="checkbox"/>
Cramps with your periods?	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal vaginal discharge?	<input type="checkbox"/>	<input type="checkbox"/>
Pelvic/abdominal pain?	<input type="checkbox"/>	<input type="checkbox"/>
Breasts?	<input type="checkbox"/>	<input type="checkbox"/>
PMS?	<input type="checkbox"/>	<input type="checkbox"/>
Any urinary problems, burning, frequency, loss of urine?	<input type="checkbox"/>	<input type="checkbox"/>
Physical/mental/sexual abuse?	<input type="checkbox"/>	<input type="checkbox"/>
Since your last visit, have you had any:		
Medical Problems?	<input type="checkbox"/>	<input type="checkbox"/>
Sexual Problems?	<input type="checkbox"/>	<input type="checkbox"/>
Surgeries?	<input type="checkbox"/>	<input type="checkbox"/>
Change in family history?	<input type="checkbox"/>	<input type="checkbox"/>
Are you at increased risk for osteoporosis?		
Family history?	<input type="checkbox"/>	<input type="checkbox"/>
Menopause?	<input type="checkbox"/>	<input type="checkbox"/>
Loss of height?	<input type="checkbox"/>	<input type="checkbox"/>
History of steroid therapy?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any nutritional concerns?		
Weight gain/loss?	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol/Triglycerides?	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>

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

	YES	NO	
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	How much? _____
Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	How much? _____
Do you get calcium in your diet?	<input type="checkbox"/>	<input type="checkbox"/>	How? _____
Do you do self breast exams?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you found any problems?	<input type="checkbox"/>	<input type="checkbox"/>	
How often do you exercise? _____			How long? _____
What type of exercise? _____			

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

Patient Signature: _____