Do you have a medical advanced directive on file? ___________

WILLOW CREEK WOMEN'S CLINIC

Today's Date ______________________

PATIENT QUESTIONAIRE

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:

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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

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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? ____________________

(OVER)

REVIEW OF SYSTEMS:

YES	NO	UNSURE	General
			Recent weight change
			Fever, chills, or night sweats
			Increase drinking or urinating
			Lumps or masses
			Dizziness or lightheadedness
			Fainting
			Headaches
			Itching
			Rashes or skin problems
			Thyroid disorder
			Cancer
			Easy bruising or bleeding
			Fatigue
			Always hot or cold

YES	NO	UNSURE	BREASTS
			Lumps
			Tenderness
			Drainage from nipple
			Monthly breast self-exam

YES	NO	UNSURE	EYE,EAR,NOSE&THROAT
			Eye pain
			Glaucoma
			Blurred or double vision
			Use glasses or contact lenses
			Loss of hearing
			Ringing in ears
			Drainage from ears
			Trouble with nose or sinuses
			Teeth or gum problems
			Use dentures
			Hoarseness
			History of radiation therapy to head or neck

YES	NO	UNSURE	RESPIRATORY
			Cough
			Sputum(phlegm) production
			Pneumonia or pleurisy
			Shortness of breath w/activity
			Wheezing or asthma
			Pulmonary emboli (blood clot to the lung)

YES	NO	UNSURE	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

YES	NO	UNSURE	GASTROINTESTINAL
			Heartburn
			Addominal pain
			Nausea or vomiting
			Bloating or food intolerance
			Peptic ulcer disease
			Liver disease
			Jaundice
			Galbladder disease
			Diarrhea
			Constipation
			Black tarry stool

YES	NO	UNSURE	GENITOURINARY
			Do you get up at night to urinate?
			Pain or burning with urination
			Difficulty starting or holding urine
			Urinary or bladder infections
			Kidney or bladder stones
			Genital warts
			Gonorrhea, Syphillis,or Chlamydia
			Genital herpes
			Pain or other problems with intercourse
			Possibly pregnant
			Change in menstrual pattern
			Disabling menstrual cramps
			Unusual vaginal discharge or bleeding
			Did your mother take "DES" (Diethylstilbesterol) when pregnant with you?
			PMS (premenstrual syndrome)
			Other(describe):____________________

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YES	NO	UNSURE	MUSCULOSKELETAL
			Neck or back pain
			Joint problems
			Muscle weakness
			Night cramps
			Use a brace or splint

YES	NO	UNSURE	OTHER
			Any other concerns you wish to discuss?

Please list your main concern for today's visit:

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