



East Metro OB/GYN  
SPECIALISTS • INC

# YEARLY HEALTH QUESTIONNAIRE

Patient Name \_\_\_\_\_ ID # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

First day of your last normal menstrual period \_\_\_\_\_ Present menstrual cycle:  Regular  Irregular

Number of pregnancies \_\_\_\_\_ Number of living children \_\_\_\_\_

When was your last physical exam? \_\_\_\_\_ Primary Care Physician \_\_\_\_\_

Reason for visit:  Yearly Exam Problem(s)?  Yes  No

If problem(s), please explain \_\_\_\_\_

Are you currently taking any medications?  Yes  No If yes, please list \_\_\_\_\_

Do you have allergies to any medications?  Yes  No If yes, please explain \_\_\_\_\_

Are you sexually active?  Yes  No If yes, with  male  female

If yes, with  monogamous (one partner) for \_\_\_\_\_ months/years  not monogamous

If yes, is anything used to prevent pregnancy?

Pills  Condoms  Diaphragm  Depo-Provera shots  Withdrawal method

Vasectomy  Tubal ligation (tubes tied)  Other \_\_\_\_\_

**DIRECTIONS:** Circle Y (yes) or N (no)

Y N Do you exercise for more than 30 minutes, 3-5 times weekly?

Y N Do you constantly eat food that are fried or high in fat? Date of your last cholesterol screen \_\_\_\_\_

Y N Does anyone in your family have a history of:  Breast Cancer  Ovarian Cancer  Heart Disease  
 Hypertension  Colon Cancer  Uterus Cancer  Diabetes  Osteoporosis  
 Blood Clots (legs, lungs, etc.)

Y N Any history of a sexually transmitted disease?  Herpes  Chlamydia  Gonorrhea  
 Trichomoniasis  HPV  Syphilis  Other \_\_\_\_\_

Y N Any history of abnormal Pap with pre-cancer (dysplasia) or cancer?  
If yes, when? \_\_\_\_\_ Treatment \_\_\_\_\_

Y N Do you use tobacco products? If yes, \_\_\_\_\_ pack(s) per day.

Y N Do you use alcohol products? If yes, \_\_\_\_\_ drink(s) per day.

Y N Do you use illegal/recreational drugs? If yes, please explain \_\_\_\_\_

Y N Have you ever had surgery? If yes, please explain \_\_\_\_\_

Y N Do you have any chronic (long-term) medical problems? If yes, please explain \_\_\_\_\_

Y N Have you had a significant or persistent change in your bowel movements or blood in your stool?

Y N Do you want information on domestic violence?

Y N Do you perform breast self exam monthly?

Y N Do you take a calcium supplement?

Y N If you are over 40, have you had a baseline mammogram this year? Date of last mammogram \_\_\_\_\_

Y N If you are 50 or older, have you ever had a sigmoidoscopy/colonoscopy? If yes, date of last exam \_\_\_\_\_

Y N If you are 60 or older, has your thyroid ever been checked? If yes, when \_\_\_\_\_

Y N If postmenopausal, have you ever had a bone density test? If yes, when \_\_\_\_\_

*I understand the above information is necessary to provide me with medical care in a safe and efficient manner. I have answered all questions to the best of my knowledge. I will notify the doctor of any change in my health or medications.*

\_\_\_\_\_  
Patient/Guardian Signature Date Practitioner Signature Date

\_\_\_\_\_  
Best telephone number to reach me *FORM CONTINUED ON BACK*

	Currently	Past	Notes
<b>Constitutional</b>			
Weight loss/gain	<input type="checkbox"/>	<input type="checkbox"/>	
Fever	<input type="checkbox"/>	<input type="checkbox"/>	
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Eyes</b>			Notes
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	
Spots before eyes	<input type="checkbox"/>	<input type="checkbox"/>	
Vision changes	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Ear/Nose/Throat/Mouth</b>			Notes
Ear aches	<input type="checkbox"/>	<input type="checkbox"/>	
Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>	
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	
Mouth sores	<input type="checkbox"/>	<input type="checkbox"/>	
Dental problems	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Cardiovascular</b>			Notes
Painful breathing	<input type="checkbox"/>	<input type="checkbox"/>	
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	
Difficult breathing on exertion	<input type="checkbox"/>	<input type="checkbox"/>	
Swelling of legs	<input type="checkbox"/>	<input type="checkbox"/>	
Palpitations of heart	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Respiratory</b>			Notes
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	
Spitting up blood	<input type="checkbox"/>	<input type="checkbox"/>	
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Gastrointestinal</b>			Notes
Frequent diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	
Bloody stool	<input type="checkbox"/>	<input type="checkbox"/>	
Nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>	
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Genitourinary</b>			Notes
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	
Pain with urination	<input type="checkbox"/>	<input type="checkbox"/>	
Urgency	<input type="checkbox"/>	<input type="checkbox"/>	
Frequency of urination	<input type="checkbox"/>	<input type="checkbox"/>	
Incomplete emptying	<input type="checkbox"/>	<input type="checkbox"/>	
Leaky bladder	<input type="checkbox"/>	<input type="checkbox"/>	
Abnormal periods	<input type="checkbox"/>	<input type="checkbox"/>	
Painful intercourse	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Musculoskeletal</b>			Notes
Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Skin/Breast</b>			Notes
Pain in breast	<input type="checkbox"/>	<input type="checkbox"/>	
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	
Masses	<input type="checkbox"/>	<input type="checkbox"/>	
Rash	<input type="checkbox"/>	<input type="checkbox"/>	
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Neurological</b>			Notes
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	
Numbness	<input type="checkbox"/>	<input type="checkbox"/>	
Trouble walking	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Psychiatric</b>			Notes
Depression	<input type="checkbox"/>	<input type="checkbox"/>	
Frequent crying	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Endocrine</b>			Notes
Dry skin	<input type="checkbox"/>	<input type="checkbox"/>	
Abnormal thirst	<input type="checkbox"/>	<input type="checkbox"/>	
Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Hematologic/Lymphatic</b>			Notes
Bruise easily	<input type="checkbox"/>	<input type="checkbox"/>	
Cuts do not stop bleeding	<input type="checkbox"/>	<input type="checkbox"/>	
Enlarged lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Allergic/Immunologic</b>			Notes
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	
Drugs, other	<input type="checkbox"/>	<input type="checkbox"/>	