PRATT HEALTHCARE

Office Visit/Annual Exam Questionnaire

Name: _____ DOB: _____ Age: _____
Language: _____ Ethnicity: _____
Preferred Method of Contact: _____ Occupation: _____

Reason for Visit: _____
Do you desire STD screening: Y / N

Total # of Pregnancies: _____ Total # Miscarriages: _____
Total # of Abortions: _____ Total # of Live Births: _____

Allergies: _____

Do you use Tobacco products: YES NO FORMERLY If yes, what type: _____
Packs per day: _____ # of years smoked: _____ Are you interested in quitting? YES NO

Alcohol Use: YES NO Drug Use: YES NO FORMERLY Quit year: _____

1st day of last period: _____ How long does cycle last: _____
# of days between period: _____

Last Mammogram: _____ Last Bone Density: _____ Last Colonoscopy: _____
If over 50, have you had the pneumonia vaccine: YES NO

Method of birth control: _____ Do you need birth control: YES NO

History of abnormal PAP	YES	NO
History of pelvic infection	YES	NO
Vaginal Discharge/Irritation/Odor	YES	NO
Any abnormal bleeding	YES	NO
Loss of urine when coughing or sneezing	YES	NO
Getting up more than once per night to urinate	YES	NO
Urgency to urinate	YES	NO
Breast pain/Lumps/Fluid from nipples	YES	NO
Family/Personal history of blood clots	Yes	NO

List all surgeries: _____
_____
List any medical conditions: _____
List current medications: _____
Please circle if you or a family member have had the following:

Thyroid Disease High Blood Pressure Heart Disease Cancer Osteoporosis

*If you are interested in enrolling in NextMD, our online patient access, please provide your email address:
_____

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