Office Visit/Annual Exam Questionnaire

Name: _____ DOB: _____ Age: _____ Language: _____

Race: _____ Email: _____

Occupation: _____ Pharmacy: _____

Reason for Visit: _____

Do you desire Sexually Transmitted Disease Testing: ☐ Yes ☐ No

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

Allergies: _____

Tobacco Use: ☐ Yes ☐ No ☐ Formerly If yes, what type: _____
Packs per day: _____ # of years smoked: _____ Quit Year: _____
Are you interested in quitting: ☐ Yes ☐ No

Alcohol Use: ☐ Yes ☐ No ☐ Socially Drug Use: ☐ Yes ☐ No ☐ Formerly

1st day of Last Period: _____ How long does cycle last: _____
Method of Birth Control: _____ Do you need birth control: ☐ Yes ☐ No

Last mammogram: _____ Last Bone Density: _____ Last Colonoscopy: _____
If over 50, Pneumonia Vaccine: ☐ Yes ☐ No

History of Abnormal Pap	Yes	No
Current Vaginal Discharge/Irritation/Odor	Yes	No
Irregular Bleeding	Yes	No
Loss of Urine with cough/sneeze/exercise	Yes	No
Urgency to Urinate	Yes	No
Breast Pain/Lumps/Nipple Discharge	Yes	No
Personal/Family History of Blood Clots	Yes	No

Please list ALL surgeries: _____
_____

Chronic Medical Conditions: _____
_____

Please Circle all that apply if you have an Immediate Family Member with the following:

Thyroid Disease High Blood Pressure Heart Disease Diabetes Osteoporosis
Cancer (specify) _____