



## Office Visit/Annual Exam Questionnaire

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Language: \_\_\_\_\_

Race: \_\_\_\_\_ Email: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Occupation: \_\_\_\_\_

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

1<sup>st</sup> 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: \_\_\_\_\_

Current Medication(s): \_\_\_\_\_

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) \_\_\_\_\_