Established Patient Information Update Questionnaire

Please provide the information requested below to enable your professional healthcare provider to better assess your healthcare needs. All information on your record is confidential and cannot be released without your written permission.

Name_____ Age_____
Last First MI

Reason for visit: ☐ Routine exam ☐ Select birth control method ☐ Pregnancy or suspected pregnancy.
☐ Problem _____

Referred by _____ Primary healthcare provider _____

SINCE LAST VISIT

Yes	No	Have you had:
☐	☐	Illnesses
☐	☐	Hospitalizations
☐	☐	Injuries
☐	☐	New allergies
☐	☐	Sexually transmitted disease
☐	☐	Smoking ☐ Quit ☐ Same ☐ More
☐	☐	Consumption of alcohol ☐ Quit ☐ Same ☐ More
☐	☐	Consumption of caffeine ☐ Quit ☐ Same ☐ More
☐	☐	Use of recreational drugs
☐	☐	New illness among family members ☐ Heart attack ☐ Stroke ☐ Diabetes ☐ Cancer
☐	☐	Perform regular self breast exams
☐	☐	Have you had a partner change during the past year?
☐	☐	Are you married or partnered in any way?
☐	☐	Are you sexually active? ☐ Male partner ☐ Female partner
☐	☐	Are you interested in pregnancy?
☐	☐	Do you have STD concerns?

Date of last pelvic exam: _____
Current method of birth control:
☐ Pill ☐ Patch ☐ NuvaRing
☐ IUD ☐ Depo Provera ☐ Condoms
☐ Diaphragm ☐ Tubal ligation ☐ Vasectomy
☐ Other _____ ☐ Desiring pregnancy
☐ Not sexually active

MENSTRUAL INFORMATION

Periods are: ☐ Regular ☐ Irregular
# of days of flow (average) _____
# of days from 1st day of one period to the 1st day of the next period _____
1st day of last (most recent) period _____

Yes	No	Do you have:
☐	☐	Cramping ☐ Mild ☐ Moderate ☐ Severe
☐	☐	Abnormally heavy bleeding ☐ Clots ☐ Gushes ☐ Night floods
☐	☐	PMS ☐ Anxiety ☐ Depression ☐ Moodiness ☐ Lack of control
☐	☐	Bleeding between periods
☐	☐	Bleeding with or after intercourse
☐	☐	Pain with or after intercourse
☐	☐	Abnormal discharge
☐	☐	Hot flashes
☐	☐	Night sweats

RECENT HEALTH

Yes	No	Do you have:
☐	☐	Headaches
☐	☐	Dizziness
☐	☐	Visual problems
☐	☐	Chest pain or tightness
☐	☐	Shortness of breath
☐	☐	Palpitations or heart racing
☐	☐	Indigestion/heartburn
☐	☐	Gas/bloating
☐	☐	Bleeding from bowels ☐ Bright red ☐ Black
☐	☐	Change in bowel habits

RECENT HEALTH (cont.)

Yes	No	Do you have:
☐	☐	Bladder problems
		☐ Leakage ☐ Frequency ☐ Burning
		☐ Urgency ☐ Foul odor
		☐ Incomplete bladder emptying
☐	☐	Infertility problems
☐	☐	Sexual difficulty
☐	☐	Thyroid trouble
☐	☐	Diabetes

Since you were last seen, have you had:

Yes	No	
☐	☐	Pregnancy/Delivery
☐	☐	Surgery
☐	☐	Hospitalization
☐	☐	Major illness

If yes to any of the above, please explain:

Medications: Include prescriptions, vitamins, calcium, herbs, & over the counter medications.

Allergies: To medications and herbs.

Patient signature _____

Date _____ / _____ / _____

Print Form

Reset Form

RETURN TO HOME PAGE