METRO OBSTETRICS & GYNECOLOGY

Patient Questionnaire

Name: _____ Age: _____ Date: _____

Last Menstrual period_____ Menopausal - yes / no

Method of contraception:
Pill Ring Condom IUD Depo-Provera Tubal Ligation Vasectomy Natural Abstinence Other

Do you: Smoke Cigarettes Y / N Drink Alcohol Y / N Use Recreational Drugs Y / N

Please list your current medications (including vitamins, supplements, and over-the-counter meds)

_____

_____

Allergies to any medicines?

_____

Do you have any changes in your health, problems or concerns to be discussed today?

_____

Have you had a new sexual partner since last exam? Y / N
Would you like to be tested for HIV or SEXUALLY TRANSMITTED INFECTIONS ? Y / N

Marital Status (circle): Single Married Divorced Widowed
Sexual Preference (circle): Heterosexual Homosexual Bisexual Decline to answer

Has anyone hurt you, or threatened to hurt you? Have you been forced to have sex? Y / N

During the past month, have you been bothered by feeling down, depressed, or hopeless? Y / N
During the past month, have you been bothered by little interest or pleasure in doing things? Y / N

Would you like a nurse in the room during your examination? Y / N
Would you like a complementary consultation on skin care and/or laser hair removal? Y / N
Would you like information regarding Advanced Healthcare Directives? Y / N

Patient Signature: _____ Date: _____

FOR OFFICE USE ONLY

BP: _____/_____ **HT:** _____ **WT:** _____ **PREV WT:** _____ **BMI** _____

PAP: _____ **MAMMO:** _____ **BDT:** _____ **COLON:** _____

PCP: _____ **Pharmacy:** _____