Bellevue Obstetrics & Gynecology Associates, P.C.
HEALTH QUESTIONNAIRE – 3 Pages

Name: ____

Age: ____________________ Date of Birth: ________________________

Main Reason For Today's Visit: Yearly Exam Consultation Problem
Please explain: ____

Additional Female Problems or Concerns: ____

Have you been a patient of Dr. Michael Woods, Michelle Berlin, PA-C, or Becky Wehrbein, PA-C within the past 3 years? Yes No If yes who: ____

When was your last physical exam? ____________________________

Do you have a Primary Care Physician: Yes No Physician's Name: _________________________

MEDICAL HISTORY

Please list ALL medications you currently take including herbal drugs, vitamins, and birth control pills:

____

____

Do you have any allergies to any medications? If so please list reaction:

____

Past illnesses or serious injuries: ____

Operations you have had including year: ____

Please **CIRCLE** any of the following medical problems you have now or have had in the past:

Pacemaker-----Endometriosis-----Polycystic Ovary Disease-----Thyroid Problems-----Phlebitis
Deep Vein Thrombosis-----Depression-----Cancer-----Abnormal Pap Smears-----Hepatitis-----Vaginal Warts
Chlamydia-----Gonnorrhea-----Lung Problems-----Kidney Problems-----Heart Trouble-----Disabilities
Asthma-----Anemia-----Arthritis-----Blood Transfusions-----Diabetes-----Herpes-----High Blood Pressure
Pulmonary Embolism-----Seizures
Any Additional Medical Problems: ____

PAST OBSTETRICAL HISTORY

Number of times you have been pregnant:______________ Number of full term deliveries:____________
Number of premature deliveries:__________________ Number of miscarriages or abortions:____________
Ages of children: ____
Please CIRCLE any of the following pregnancy complications that you have had:
Toxemia-----Gestational Diabetes-----Pre-term Labor-----Hemorrhage
Any additional complications? ____

MENSTRUATION HISTORY

Age started:____________________________

First day of last menstrual period:______/______/______

Number of days your period lasts:__________________________

Number of days from start of period to next:_____________________________

Present menstrual cycle: Regular Irregular

Date of last PAP smear:______/______/______

Date of last mammogram:______/______/______

Are you currently worried or afraid of being hurt or abused?__________________________

Do you have a history of being sexually or physically abused?_______________________

Are you sexually active? Yes No If Yes, with Male Female

If Yes, are you : Monogamous (one partner) for ____________________ months/years

Not monogamous (multiple partners) for _________________________ months/years

If Yes, is anything used to prevent pregnancy: Pills Condoms Diaphragm Depo-Provera Shots

Withdrawl Method Vasectomy Tubal Ligation (tubes tied) Other: ________________________

Any chance you might be pregnant now? ____

Any history of a sexually transmitted disease(s)? Herpes Chlamydia Gonorrhea

Trichomoniasis HPV Syphilis Other: ____

FAMILY HISTORY

Please CIRCLE any of the following health problems that occur in your family:

Birth Defects------Mental Illness------Thyroid Problems------Breast Cancer------Arthritis------Diabetes

High Blood Pressure------Osteoporosis------TB------Stroke------Heart Disease------Cancer------Colon Cancer

Ovarian Cancer------Uterus Cancer------Blood Clots(legs, lungs, etc.)

Major illnesses or cause of death

Father:____

Paternal Grandfather:_________________________________

Paternal Grandmother:__________________________________

Mother:____

Maternal Grandfather:_______________________________________

Maternal Grandmother:__________________________________

Brothers and or Sisters:__________________________________

SOCIAL HISTORY

Occupation:____ Full or Part-time

Do you smoke? Yes No If yes, how much per day? __________ How many years? ________________

Do you drink alcohol? Yes No If yes, how many drinks per day or week? _______________________

Do you exercise for more than 30 minutes, 3 – 5 times weekly? Yes No

Do you consistently eat foods that are fried or high in fat? Yes No

Date of your last cholesterol screening: __________________________

Do you use illegal / recreational drugs now or have you used any in the past? Yes No

If yes, Please list:____

Do you wear your seat belt regularly?: Yes No

REVIEW OF SYSTEMS

Please **CIRCLE** any of the following medical problems that you are CURRENTLY suffering from:

General: Fatigue------Fever------Weight Gain > 10 lbs------Weight Loss < 10 lbs.
Skin: Dryness------Excessive Body Hair------Hair Loss------Nail Changes------Itching------Rash
HENT: Nasal Problems------Headache------Decreased Hearing------Earache------Ringing in the Ears------ Bleeding Gums
Eyes: Visual Disturbances------Blurred Vision
Neck: Neck Pain------Neck Stiffness------Swollen Glands
Respiratory: Asthma------Bronchitis------Chronic Cough------Painful Breathing------Coughing up blood Wheezing
Breast: Breast mass-------Breast pain------Dimpling------Nipple discharge------Nipple pain------ Nipple inversion-------Skin Changes------Nipple Retraction
Cardiovascular: Chest Pain------Swelling in Ankles------High Blood Pressure Trouble breathing while lying down------Palpitations
Gastrointestinal: Abdominal mass------Abdominal pain------Change in bowel habits------Constipation Diarrhea-----Painful swallowing-----Jaundice-----Nausea-----Rectal Bleeding----Vomiting
Female Genitourinary: No periods------Painful urination-----Change in urinary stream------Decrease sex drive Painful periods-----Painful intercourse------Frequent urination-----Blood in the urine Hot flashes------Leaking urine------Irregular periods-----Bleeding in between periods Pelvic pain----Painful bowel movements-----Urinary retention-----Vaginal bleeding Vaginal discharge-----Possible STD's-----Vaginal dryness----Vaginal Bulge
Musculoskeletal: Back Pain-----Joint pain-----Muscle weakness-----Muscle pain
Neurological: Dizziness-----Numbness-----Seizures-----Sensory changes
Psychiatric: Anxiety----Crying spells----Depression----Increase in sleeping pattern---Inability to concentrate Insomnia-----Suicidal thoughts
Endocrine: Appetite changes-----Always cold-----Hair changes-----Always hot-----Always thirsty
Hematology: Anemia-----Easy bruising-----Nose bleeds-----Prolonged bleeding
Allergic: Any food allergies or seasonal allergies (please list): ____
Additional Comments or Explanations:____

Do you perform monthly self breast exams? Yes No
Do you take a calcium supplement? Yes No
If you are over 40, Have you had a baseline mammogram? Yes No If so when?_____________________
If you are 50 or older, have you ever had a sigmoidoscopy or colonoscopy? Yes No If so when?_______
If you are 60 or older, has your thyroid ever been checked? Yes No If so when?______________________
If postmenopausal, have you ever had a bone density test? Yes No If so when? _____________________

I understand the above information is necessary to provide me with medical care in a safe and efficient manner. I have answered all questions to the best of my knowledge. I will notify the doctor of any changes in my health or medications.

Patient Signature____ **Date**________________________________