Form must be filled out completely. Please check ☐ (Box) labeled "None" or "No" if it does not apply.

Interval Patient Health History Questionnaire

Name: _____ **DOB:** _____ **Age:** _____

E-mail:

(E-mail address needed to access Web Portal) **Phone #**: _____

Address: _____

Local Pharmacy: _____ **Pharmacy Phone # *or* Address:** _____

Mail Order Pharmacy: _____ Compounding Pharmacy: _____

Insurance Main Card Holder? ☐ Self ☐ Spouse ☐ Parent

Spouse or Parent Name _____ **DOB:** _____

I give permission to Plano Wellness personnel to give any and all medical information pertaining to myself, including appointment reminders, **to the individual other than myself:**

Name: _____ **Phone #** _____ **Relationship** _____

Reason for today's visit *(check all that apply)*

☐ Annual ☐ BioTE® ☐ Hormone Problems ☐ Abnormal Pap ☐ Abnormal Bleeding
☐ Abnormal Imaging ☐ Birth Control ☐Surgery ☐ Second opinion ☐ Other_____

Health Screening

Tobacco: ☐ Never Current: ☐ Sporadic ☐ Daily ☐Former, Quit ____/____/_____

Have you completed the 3-part HPV/Gardasil vaccine? ☐No ☐Yes ***If yes, when?*** ____/____/_____

Is your Tetanus vaccine current? ☐No ☐Yes

Alcohol: ☐ Never Current: ☐ Sporadic ☐ Daily ☐Former, Quit ____/____/_____

Exercise: ☐ Never Current: ☐ Sporadic ☐ 3-4x/wk ☐ Daily

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed ☐Remarried

Primary Care Physician: _____

Approximate date of last:	
Tdap	
Pap Smear	
Mammogram	
Colonoscopy	
Bone Density	
Blood Work	

OFFICE USE ONLY	
Ht:	**Wt:**
BP:	**P:**
Temp:	
UA:	

Current Medication: ☐ None	**Strength:**	**Taken how often:**

Since your last visit, have you been diagnosed with any of the following? ☐ None

- ☐ AIDS
- ☐ Alzheimer's disease
- ☐ Anemia
- ☐ Anxiety disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood clotting disorder
- ☐ Breast cancer
- ☐ Cardiac arrhythmia
- ☐ Cholesterol(Hypercholesterolemia)
- ☐ Colon cancer
- ☐ Congestive heart disease
- ☐ COPD (Lung disease)
- ☐ Coronary heart disease
- ☐ Depression
- ☐ Diabetes
- ☐ DVT (venous embolism)
- ☐ Epilepsy
- ☐ Esophageal reflux
- ☐ Fibromyalgia
- ☐ Genetic disorder
- ☐ Hepatitis (**A**, **B**, or **C**)
- ☐ Hernia
- ☐ HIV
- ☐ Hypertension (HTN)
- ☐ Irritable Bowel Syndrome (IBS)
- ☐ Kidney stone
- ☐ Lung cancer
- ☐ Migraine headaches
- ☐ Mitral valve prolapse (MVP)
- ☐ Myocardial infarction
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Skin cancer
- ☐ Stroke (CVA)
- ☐ Suicide
- ☐ Thyroid (**Hypo** or **Hyper**)
- ☐ Transient Ischemic attack
- ☐ Triglycerides, Elevated
- ☐ Ulcer
- ☐ Other:_____
  _____
  _____
  _____

Have you ever been hospitalized? ☐No ☐Yes

Since your last visit, have YOU had surgery? ☐No ☐Yes
If yes, please explain: _____

Since your last visit, have you been diagnosed with any NEW allergies to medication, food or environmental allergens? ☐No ☐Yes
If yes, please explain: _____

Since your last visit, has any FAMILY member been diagnosed with a NEW medical condition or cancer? ☐No ☐Yes
If yes, please explain: _____

Has a FAMILY member ever had genetic testing for Hereditary cancer risk? ☐No ☐Yes
If yes, please explain: _____

GYN History

First day of Last Menstrual Cycle: ____/____/_____
Period started: Age _____ Date: ____/____/_____ **Menopause:** Age _____ Date: ____/____/_____
Not having periods: ☐Nursing ☐Birth Control ☐Menopause ☐Endometrial Ablation ☐Hysterectomy ☐Unknown
Menstrual Timing: ☐Regular Cycle ☐Irregular Cycle every: ____days ____weeks ____months
Menstrual Length: ____days Flow: ____Heavy days ____Moderate days ____Light days
Cramps: ☐No ☐Yes Clots: ☐No ☐Yes
Are you sexually active? ☐No ☐Yes **Is your intimate life satisfactory?** ☐No ☐Yes
Hx of physical, emotional or sexual abuse? ☐No ☐Yes **Sexual Preference:** ☐Male ☐Female
Are you trying to conceive? ☐No ☐Yes ***If yes, for how long?*** _____

Method of birth control you are using?

- ☐ *Not sexually active yet*
- ☐ *None, would welcome pregnancy*
- ☐ *None, History of Infertility*
- ☐ Abstinence
- ☐ Birth Control Pill
- ☐ Condoms
- ☐ Depo Provera
- ☐ Diaphragm
- ☐ Essure
- ☐ IUD 3 yr Progestin
- ☐ IUD 5 yr Progestin
- ☐ IUD 10 yr Copper
- ☐ Natural Family Planning
- ☐ Hysterectomy
- ☐ Patch
- ☐ Vaginal Ring
- ☐ Progestin Implant
- ☐ Rhythm
- ☐ Salpingectomies, Bilateral
- ☐ Same sex partner
- ☐ Tubal Ligation, Bilateral
- ☐ Vaginal hormone inset
- ☐ Vaginal spermicide
- ☐ Vasectomy
- ☐ Withdrawal

Past GYN History - **Do you have or have you ever had:** ☐ **None**

- ☐ Abnormal Pap Smear
- ☐ Amenorrhea (No periods)
- ☐ Anovulation
- ☐ Bartholin's gland cyst
- ☐ Cervical cancer
- ☐ Candidiasis (chronic yeast)
- ☐ Chlamydia
- ☐ Condyloma (genital warts)
- ☐ Cryotherapy
- ☐ Cystocele (dropped bladder)
- ☐ DES exposure in utero
- ☐ Dysplasia (pre-cancer)
- ☐ Dyspareunia (painful sex)
- ☐ Endometriosis
- ☐ Fibroid uterus
- ☐ Gonorrhea
- ☐ Heavy periods
- ☐ Herpes, genital
- ☐ HPV
- ☐ Hydrosalpinx
- ☐ Incontinence
- ☐ Infertility
- ☐ Irregular menses
- ☐ LEEP
- ☐ Ovarian cancer
- ☐ Ovarian problems
- ☐ Pelvic adhesions
- ☐ PID
- ☐ PMS
- ☐ Polycystic Ovaries (PCOS)
- ☐ Syphilis
- ☐ Trichomonas
- ☐ Uterine cancer
- ☐ Uterine Polyps
- ☐ Uterine Prolapse
- ☐ Vaginal or Vulvar Cancer

Review of Systems: *(Please circle any you **currently** have):* ☐**None**

General	Chills Fatigue Fever Night sweats Weight gain Weight loss
Eyes	Blind spots Floaters in the visual field Eye pain
Ears, Nose, Throat, Neck	Bleeding gums Hoarseness Swollen neck Decreased hearing Difficulty swallowing Nosebleed
Endocrine	Cold intolerance Heat intolerance Hair loss Hot flashes Excessive hair growth Thirst Breast discharge
Respiratory	Hemoptysis (bloody cough) Shortness of breath Wheezing
Cardiac	Faint Chest pain Palpitations Shortness of breath at rest
GI	Abdominal pain Blood in stool Constipation Diarrhea Nausea Vomiting
Heme/Lymph	Anemia Easy bruising Prolonged bleeding Swollen glands
GU	Nocturia (urination at night) Pelvic pain Vaginal dryness Vaginal discharge Vaginal itching Vaginal burning Low sex drive Difficult to climax Painful intercourse Blood after intercourse Blood in urine Frequent urination Painful urination
Musculoskeletal	Back problems (pain) Painful joints Weakness Swollen joints
Skin	Acne Dry skin New mole Rash
Neurologic	Dizziness Headache Poor memory Tingling/Numbness
Psychiatric	Irritability Anxiety Depressed mood Difficulty sleeping Suicidal thoughts Insomnia