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All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):*	**DOB:**
Purpose of today's visit:	

CURRENT LIST OF MEDICATIONS

List your prescribed drugs and over-the-counter medications, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken	Name of Drug	Strength	Frequency Taken

ALLERGIES TO MEDICATIONS

Name the Drug	Reaction You Had

MEDICAL HISTORY (check all that apply)

☐ Asthma ☐ Migraines ☐ Cancer ☐ Diabetes ☐ Thyroid Disorder ☐ Bladder Infection ☐ High Blood Pressure

☐ Blood Clots ☐ Glaucoma ☐ Arthritis ☐ Stroke ☐ Other:

Surgeries

Year	Reason	Hospital

DATE OF LAST COLONOSCOPY:

OTHER HOSPITALIZATIONS

Year	Reason	Hospital

FAMILY HISTORY			
	AGE	**ALIVE OR DECEASED**	**SIGNIFICANT HEALTH PROBLEMS**
Father		☐ Alive ☐ Deceased	
Mother		☐ Alive ☐ Deceased	
Grandfather *Paternal*		☐ Alive ☐ Deceased	
Grandmother *Paternal*		☐ Alive ☐ Deceased	
Grandfather *Maternal*		☐ Alive ☐ Deceased	
Grandmother *Maternal*		☐ Alive ☐ Deceased	
Sibling	☐ M ☐ F	☐ Alive ☐ Deceased	
	☐ M ☐ F	☐ Alive ☐ Deceased	
	☐ M ☐ F	☐ Alive ☐ Deceased	
	☐ M ☐ F	☐ Alive ☐ Deceased	
	☐ M ☐ F	☐ Alive ☐ Deceased	
	☐ M ☐ F	☐ Alive ☐ Deceased	

DO YOU HAVE A FAMILY HISTORY OF : (check any that apply)		
☐ Breast Cancer	☐ Ovarian Cancer	☐ Colon Cancer

HEALTH HABITS AND SOCIAL HISTORY						
Exercise	☐ Sedentary (No exercise)	☐ Mild exercise	☐ Occasional vigorous exercise	☐ Regular vigorous exercise		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Sodas	# Of cups/ cans per day? :	
Alcohol	Do you drink alcohol? : ☐ Yes ☐ No				More than 3 drinks per week? : ☐ Yes ☐ No	
Tobacco	Do you use or have you ever used tobacco?: ☐Yes ☐No ☐ Cigarettes –pks./day _____ ☐ Vapes- # per day _____ ☐ # of years _____ ☐ Or year quit it_____					
	Are You sexually active: ☐Yes ☐No					
Marital status:	☐ Single	☐ Partnered	☐ Married	☐ Separated	☐ Divorced	☐ Widowed
Occupation			Spouse's Occupation			

GYNECOLOGIC HISTORY		
Number of times you have been pregnant:	**Number of live births :**	
Number of miscarriages:	**Number of terminations/ abortions:**	
Date of last pap smear:	**Was it normal?: ☐Yes ☐No**	**Have you EVER had an abnormal pap smear?: ☐Yes ☐No**
Date of last period:	**Date of Last Mammogram:**	**Date of last Bone Density:**

WHAT FORM OF BIRTHCONTROL DO YOU USE (CHECK ANY THAT APPLY)

☐ ABSTINENCE ☐ CONDOMS ☐ BIRTHCONTROL PILLS ☐ MIRENA IUD ☐ SKYLA IUD ☐ PARAGARD IUD ☐ KYLEENA

☐ NUVARING ☐ BILATERAL TUBAL LIGATION ☐ DEPOPROVERA ☐ORTHO EVRA PATCH ☐ SPERMICIDE ☐ HYSTERECTOMY

☐ MENOPAUSE ☐ NEXPLANON ☐NONE ☐ OTHER:

HAVE YOU EVER HAD A SECUALLY TRANSMITTED INFECTION? (CHECK ANY THAT APPLY)

☐ GONORRHEA ☐ CHLAMYDIA ☐ TRICHOMONAS ☐ GENITAL HERPES ☐ HEPATITIS B ☐ SYPHILIS ☐ HIV/AIDS

☐ GENITAL WARTS ☐ HUMAN PAPILLOMA VIRUS (HPV)