

SAND POINT INTERNISTS

FEMALE PATIENT HEALTH QUESTIONNAIRE

PATIENT NAME: _____ TODAY'S DATE: _____ AGE: _____

REASON FOR TODAY'S VISIT: _____

DATE OF LAST PHYSICAL EXAM: _____

MEDICAL HISTORY

Serious Injuries / Illnesses / Medical Problems (i.e. cancer, heart disease, high blood pressure, pneumonia)

Previous Hospitalizations and Surgeries: _____

Medications (please list name of medication, dose, and frequency): _____

Number of pregnancies ____ # of live births ____ # of miscarriages ____ # of abortions ____
Age at 1st menstrual cycle ____ Age at menopause ____ Date of last pap smear ____
Date of last menstrual period ____ Days in menstrual cycle ____ Pain with Periods? ____
History of Irregular Periods? ____ History of Abnormal Paps? If yes, please list date ____
History of sexually transmitted disease? ____ Type of Birth Control used: ____
Date of any Cervical Surgery/Freeze _____

Date of last bone density exam _____ Date of last mammogram _____

Date of last colonoscopy _____

Have you had the Pneumonia (pneumovax) vaccine? Yes (date) _____ No

When was your last tetanus vaccine? _____

Known Allergies to Medicine (please list name of medication(s) and any reaction): _____

Names of Other Physicians you have seen: _____

Name of Physician you are seeing currently: _____

PATIENT SOCIAL HISTORY

Marital Status: _____ Sexual Orientation (optional): _____ Current Occupation: _____

Use of Alcohol Never ____ Rarely ____ Moderate ____ Weekly ____ Daily ____

Use of Caffeine Never ____ Cups per day of Coffee ____ Soda ____ Tea ____

Use of Tobacco Never ____ Current ____ Previously, but quit ____ # of years smoked ____ Current pks/day ____

Use of Street Drugs Never ____ Type? _____ How Often? _____

Exercise Never ____ Rarely ____ Weekly ____ Daily ____ Type of Exercise: _____

FAMILY MEDICAL HISTORY

Have any of your blood relatives had major medical problems such as diabetes, cancer (indicate type), high blood pressure, heart disease, stroke or genetic disorder? Do any diseases or problems "run in the family"? Please indicate below:

Father:	Father's Father:
Mother:	Father's Mother:
Brothers:	Mother's Father:
Sisters:	Mother's Mother:
Children:	Other:

Does your spouse / significant other have any major medical problems: _____

**ARE YOU EXPERIENCING OR CONCERNED ABOUT ANY OF THE FOLLOWING?
(circle appropriate answer)**

CONSTITUTIONAL SYMPTOMS

Unexplained weight gain or loss..... yes no
 Fever or chills..... yes no
 Night sweats / hot-flashes..... yes no
 Fatigue..... yes no

HEMATOLOGIC / LYMPHATIC

Bleeding or bruising tendency..... yes no
 Anemia..... yes no

EARS / NOSE / MOUTH / THROAT

Hearing loss or ringing yes no
 Earaches or drainage..... yes no
 Chronic sinus problem yes no
 Sinus Pressure / Pain yes no
 Recurrent nose bleeds..... yes no
 Bleeding gums..... yes no
 Sore throat or voice change (hoarseness)... yes no
 Hay fever yes no

CARDIOVASCULAR

Heart Trouble..... yes no
 Chest pain or angina pectoris..... yes no
 Palpitation (fast or irregular heartbeat).. yes no
 Shortness of breath while walking or lying flat. yes no
 Swelling of feet, ankles or hands..... yes no
 High blood pressure..... yes no

RESPIRATORY

Chronic or frequent coughs..... yes no
 Spitting up blood..... yes no
 Shortness of breath..... yes no
 Asthma or wheezing..... yes no

GASTROINTESTINAL

Loss of appetite..... yes no
 Change in bowel movements..... yes no
 Nausea or vomiting..... yes no
 Frequent diarrhea..... yes no
 Painful bowel movements or constipation.... yes no
 Rectal pain, bleeding, blood in stool..... yes no
 Abdominal pain or heartburn..... yes no
 Peptic ulcer yes no
 Trouble swallowing..... yes no

Burning or painful urination..... yes no
 Blood in urine..... yes no
 Increased Urination at night yes no
 Incontinence yes no
 Dribbling? yes no
 Decrease in Urine Stream..... yes no
 Kidney stones..... yes no
 Sexual difficulty..... yes no
 Slow to start/stop urination yes no

MUSCULOSKELETAL

Joint pain..... yes no
 Joint stiffness or swelling..... yes no
 Back pain..... yes no

INTEGUMENTARY (Skin)

Rash or itching..... yes no
 Concern about moles..... yes no

BREAST

Breast pain..... yes no
 Breast lump..... yes no
 Breast discharge..... yes no

NEUROLOGICAL

Headaches..... yes no
 Convulsions or seizures..... yes no
 Numbness or tingling yes no
 Weakness..... yes no
 Memory loss or confusion..... yes no
 Dizziness or vertigo yes no

ENDOCRINE

Thyroid disease..... yes no
 Diabetes..... yes no
 Other glandular or hormone problem.. yes no

OTHER

Nervousness..... yes no
 Depression yes no
 Insomnia..... yes no
 Anxiety / Panic yes no
 Suicidal thoughts..... yes no
 Do you feel safe in your relationship with your significant other and/or family members? yes no

Other concerns not noted above:

Physician's Initials: _____

Date: _____

GENITOURINARY

Frequent urination..... yes no