HENDERSON & WALTON
WOMEN'S CENTER, P.C.

HENDERSON & WALTON WOMEN'S CENTER, P.C. *Physician:* Select One *Office Location:* Select One

ANNUAL PATIENT QUESTIONNAIRE

NAME _____

AGE _____ **DATE** _____

Please list current medications including dosage and frequency:

NAME OF MEDICATION	**DOSAGE**	**FREQUENCY TAKEN**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SEASONAL VACCINES THIS YEAR ☐ Pneumonia ☐ FLU **HAVE YOU EVER HAD THESE VACCINES?** ☐ SHINGLES ☐ TDAP ☐ Gardasil

PLEASE LIST ANY/ALL DRUG ALLERGIES: _____

LIST ANY CHANGES IN YOUR FAMILY MEDICAL HISTORY _____

CHANGES IN YOUR PERSONAL LIFE _____

HAVE YOU BEEN DIAGNOSED WITH ANY CHRONIC ILLNESSES (check all that apply)

☐ Heart Disease
☐ Diabetes
☐ Lung Disease
☐ Kidney Disease
☐ Sexually Transmitted Disease
☐ Genetic Disorder
☐ Seizure Disorder
☐ Anemia
☐ Other _____
☐ Alcohol Use: ☐ Socially ☐ Rarely ☐ Frequently
☐ Drug Use ☐ Smoking
☐ Mental Illness ☐ Hypertension

Since your last visit, have you:
Had surgery? ☐ Yes ☐ No ***If yes, approx. type and date of surgery*** _____

Been diagnosed or treated for a new illness/injury? ☐ Yes ☐ No ***If yes, please describe***
_____
_____

Are you sexually active? ☐ Yes ☐ No ☐ Never **Last Menstrual Cycle?** _____

What method of birth control do you *currently* use? Check *all* that apply:

☐ Pills ☐ Patch ☐ Ring ☐ Condom ☐ IUD ☐ Tubes Tied ☐ Nothing

☐ Essure ☐ Spermicide ☐ Withdrawal ☐ Timing ☐ Shot ☐ Vasectomy

PATIENT SIGNATURE: _____ _____ **RN/CA**

Click "Send" to email form to Henderson & Walton Women's Center **Send**