

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

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Physician:

Office Location:

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)

<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Genetic Disorder	<input type="checkbox"/> Alcohol Use: ___ Socially ___ Rarely ___ Frequently
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> Drug Use <input type="checkbox"/> Smoking
<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Anemia	<input type="checkbox"/> Mental Illness <input type="checkbox"/> Hypertension
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Other _____	
<input type="checkbox"/> Sexually Transmitted Disease	_____	

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:

<input type="checkbox"/> Pills	<input type="checkbox"/> Patch	<input type="checkbox"/> Ring	<input type="checkbox"/> Condom	<input type="checkbox"/> IUD	<input type="checkbox"/> Tubes Tied	<input type="checkbox"/> Nothing
<input type="checkbox"/> Essure	<input type="checkbox"/> Spermicide	<input type="checkbox"/> Withdrawal	<input type="checkbox"/> Timing	<input type="checkbox"/> Shot	<input type="checkbox"/> Vasectomy	

PATIENT SIGNATURE: _____ RN/CA