About Women by Women

Established Patient Questionnaire

_____
Today's Date

Name:	Birth Date: / /
	Home Phone:
Address:	Work Phone:
	Cell Phone:

Why have you come to the office today?	Have you ever been sexually active? ☐ Yes ☐ No
☐ Annual Exam	Are you currently sexually active? ☐ Yes ☐ No
☐ Other:	Do you have any sexual concerns? ☐ Yes ☐ No
First day of your last period: / /	Do you use anything for contraception?
Date of your last mammogram: / /	
Last colorectal screening (exam for blood in stool or sigmoidoscopy/colonoscopy) : / /	
Allergies, if any (describe reaction):	
Have you had any major illnesses, injuries or surgeries since your last visit:	
Have there been any changes in family health since your last visit (for example, new diagnoses of diabetes, heart disease, high cholesterol, high blood pressure, blood clots, etc.):	

Social History	**Y**	**N**			
Do you smoke?			____ packs per day for ____ years		
Do you drink alcohol?			____ drinks per week		
Do you exercise?			____ times per week		
Do you drink caffeine?			____ cups per day		
Do you wear your seatbelt?					
Do you wear sunscreen?				**Y**	**N**
Are there any health hazards at home or work?			Have you been hurt or threatened by anyone?		
Does your diet include calcium?			Does your diet include folic acid?		
How would you describe your diet?					

Have *you* been diagnosed with: ☐ Breast Cancer ☐ Ovarian Cancer

Have any of your relatives been diagnosed with **Breast Cancer**? And at what age?				Have any of your relatives been diagnosed with **Ovarian Cancer**? And at what age?			
Your mother's side	Age	Your father's side	Age	Your mother's side	Age	Your father's side	Age
☐ Mother	_____	☐ Father	_____	☐ Mother	_____	☐ Grandmother	_____
☐ Your sister	_____	☐ Grandmother	_____	☐ Your Sister	_____	☐ Aunt	_____
☐ Your brother	_____	☐ Grandfather	_____	☐ Grandmother	_____	☐ Cousin	_____
☐ Grandmother	_____	☐ Aunt	_____	☐ Aunt	_____		
☐ Grandfather	_____	☐ Uncle	_____	☐ Cousin	_____		
☐ Aunt	_____	☐ Cousin	_____				
☐ Uncle	_____						
☐ Cousin	_____						

Are you aware of anyone in your family with prostate cancer or pancreatic cancer?

Name:	Birth Date: / /

Have *you* been diagnosed with: ☐ **Colon Cancer** ☐ **Uterine Cancer**

Have any of your relatives been diagnosed with **Colon or Uterine Cancer?** At what age?

Your mother's side	Age	Your father's side	Age
☐ Mother	_____	☐ Father	_____
☐ Your sister	_____	☐ Grandmother	_____
☐ Your brother	_____	☐ Grandfather	_____
☐ Grandmother	_____	☐ Aunt	_____
☐ Grandfather	_____	☐ Uncle	_____
☐ Aunt	_____	☐ Cousin	_____
☐ Uncle	_____		
☐ Cousin	_____		

Are you aware of any relatives who have been diagnosed with other cancers?

_____

_____

_____

_____

_____

Have you experienced any of the following symptoms?

1.	Constitutional	☐ None	☐ Weight gain ☐ Weight loss	☐ Fever ☐ Fatigue	☐ Other:
2.	Eyes	☐ None	☐ Vision changes ☐ Glasses/contacts	☐ Other:	
3.	Ear, nose, throat	☐ None	☐ Headache ☐ Hearing loss	☐ Sinusitis ☐ Sore throat	☐ Other:
4.	Heart	☐ None	☐ Swelling ☐ Chest pain	☐ Palpitation ☐ Difficulty breathing on exertion	☐ Other:
5.	Lungs	☐ None	☐ Wheezing ☐ Cough	☐ Shortness of breath ☐ Other:	
6.	Stomach, intestines	☐ None	☐ Constipation ☐ Diarrhea	☐ Bloody stool ☐ Pain	☐ Nausea/indigestion ☐ Other:
7.	Vagina, bladder	☐ None	☐ Abnormal or painful periods ☐ Abnormal vaginal bleeding ☐ Abnormal vaginal discharge	☐ Painful intercourse ☐ Painful urination ☐ Frequent urination	☐ Leakage of urine ☐ Blood in urine ☐ Other:
8.	Muscles, bones	☐ None	☐ Muscle weakness ☐ Muscle or joint pain	☐ Other:	
9.	Skin	☐ None	☐ Rash ☐ Dry skin	☐ Worrisome moles	☐ Other:
10.	Breasts	☐ None	☐ Pain ☐ Lump(s)	☐ Nipple discharge ☐ Other:	
11.	Nerves	☐ None	☐ Memory problems ☐ Trouble walking	☐ Dizziness ☐ Numbness	☐ Other:
12.	Mood	☐ None	☐ Anxiety ☐ Depression	☐ Crying	☐ Other:
13.	Hormones	☐ None	☐ Hot flashes ☐ Hair loss	☐ Heat or cold intolerance ☐ Other:	
14.	Blood	☐ None	☐ Bleeding ☐ Bruising	☐ Swollen lymph node(s) ☐ Other:	

Reviewed by Clinician: _____ Date: _____