# New Patient Adult Female Medical Questionnaire

Name:________________________________________________________

S / M / D / W/ P __________________ Children Y / N__________________________

Who makes medical decisions for you if you are not able to?

Name______________________ Relationship________________________

Occupation:__________________________________________________________

Hobbies/Interests:___________________________________________________________

Do you have a Living Will or Advanced Directives? Y / N

If not are you interested in materials on how to make one? Y / N

**What is the reason for your visit today?**_______________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**Current & Past Medical Problems**

__________________________________
__________________________________
__________________________________
__________________________________
__________________________________
__________________________________
__________________________________
__________________________________

**Current Medications** (name & dose)
Please include vitamins, etc.

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________________________________
________________________________
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**Allergies** to medications, food or X-ray dye_____________________________

Pharmacy Name and Phone Number _____________________________________

**Past Surgical History, Operations, and Hospitalizations (include dates)**

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

| Have you had any Blood Transfusions? When? | | Tetanus Shot (Date) | |
|---|---|---|---|
| Drink Alcohol x per week | | Pneumonia Shot (Date) | |
| Smoke Packs per day Number of Years | | Flu Shot (Date) | |
| Last Blood Work (Date) | | Colonoscopy (Date) | |
| | | Dexa Scan (Date) | |

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**Review Of Systems**
**(Check any you are currently experiencing or have significant history of)**

| Current | Past | | Current | Past | |
|---|---|---|---|---|---|
| | | Weight Loss | | | Nausea |
| | | Weight Gain | | | Constipation |
| | | Fever | | | Blood in Stool |
| | | Chills | | | Diarrhea |
| | | Rash | | | Frequent Urination |
| | | Headaches | | | Painful Urination |
| | | Eye Problems | | | Painful/Frequent Periods |
| | | Allergies | | | Loss of Libido |
| | | Ear Infection | | | Hair Loss |
| | | Sinus Infections | | | Too Hot/Too Cold |
| | | Sore Throat | | | Joint Pain |
| | | Shortness of breath | | | Anxiety/Daily Worry |
| | | Wheezing or Asthma | | | Depression |
| | | Cough | | | Panic Attacks |
| | | Chest Pain or Pressure | | | Obsessive/Compulsive |
| | | Funny or Rapid Heartbeat | | | Mania |
| | | High Blood Pressure | | | Considered/Attempted Suicide |
| | | Difficulty Swallowing | | | Alcohol Abuse |
| | | Indigestion/Heartburn | | | Drug Abuse |
| | | Barrets Esophagus | | | Sleep disorder |

**Family History**

| | Living or Deceased | Age (Current or at time of death) | List All Medical Problems |
|---|---|---|---|
| Father | | | |
| Mother | | | |
| Siblings | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**For Women Only:**

______________Name of Gynecologist
______________Date of Last Pap
______________History of Abnormal Paps
______________Date of Last Mammogram
______________Date of Last period

_____________# Pregnancies
_____________# Births
_____________# Miscarriages/Other
_____________Current Contraception
_____________Years of Post Menopausal HormoneUse

Relatives with Breast or Ovarian Cancer_____________________________________________________
______________________________________________________________________________