Chart # ___________

Ferns, Matile, Perryman & Moore, MD's, PC

Comprehensive Patient Questionnaire

Name ______________________________ Date of Birth ___________ Age _________ Date ________

Social History

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Do you use alcohol? ☐ Yes ☐ No Type _____________ How much ____________ # of Yrs ______

Do you use tobacco? ☐ Yes ☐ No How much ___________ # of Yrs _____ Ever quit before _______

Do you use recreational drugs? ☐ Yes ☐ No Type ___________ How much _________ # of Yrs ____

Your occupation ____

Obstetric History

Total # of pregnancies _______ # of live births _______ # of premature births _______

miscarriages_______ # elective abortions _______ # living children _______

# Preg	Birthdate	Wks Preg	Wt	Sex	Type of Delivery	Notes	# Preg	Birthdate	Wks Preg	Wt	Sex	Type of Delivery	Notes
1							4						
2							5						
3							6						

Gynecology History & Review of Systems

Age of 1st period __________________________ Age of menopause ________________________

First day of your last period ________________ # days between periods ____________________

How many days do you flow ________________ Use Tampons? ___________ Pads? __________

Do you have painful periods ________________ ☐ light periods ☐ moderate periods ☐ heavy periods

What relieves your cramps __________________

When was your last pap smear _______________ Where _______________ Result _______________

Have you ever had an abnormal pap ___________ When _______________ Treatment _____________

Have you had cervical dysplasia (pre-cancer) __________________________

Last mammogram __________________ Result _____________________________

Have you ever had a breast biopsy ______________ When ____________ Result ___________________

Have you ever been sexually active? __________________ Are you now? ________________________

New partner in past 6 months? _____________ Age of 1st sexual experience ___________

# of lifetime sexual partners ___________ Sex with males _____, females _____, or both _____

What are you using for birth control now? ☐ Foam ☐ Condoms ☐ IUD ☐ Implant ☐ Diaphragm

☐ Tubal ligation ☐ Vasectomy ☐ Birth control pill ☐ Vaginal Ring ☐ Withdrawal

☐ Natural Family Planning ☐ Other ____

Do you have now or have you ever had:

☐ Chlamydia/Gonorrhea ☐ Painful Intercourse ☐ Ectopic Pregnancy

☐ Genital Warts ☐ Endometriosis ☐ Infertility

☐ Genital Herpes ☐ Uterine Fibroids ☐ Urinary Incontinence

☐ AIDS test ☐ Breast Cancer ☐ Bowel Incontinence

Have you had all three of the Gardasil or Cervarix (HPV) Vaccines? ___________________________

Chart # ____________

Medical History

Do **YOU** have or have you had (*please include details if pertinent*):

☐ Heart Disease
☐ Heart Murmur
☐ High Blood Pressure
☐ Blood Clotting Disorder
☐ DVT (blood clot)
☐ Mitral Valve Prolapse
☐ High Cholesterol
☐ Bleeding Disorder
☐ Epilepsy or Seizures
☐ Drug Problem
☐ Alcohol Problem
☐ Depression
☐ Colitis or Diverticulitis
☐ Reflux or GERD or Ulcer
☐ Migraines
☐ Blood Transfusion
☐ Cancer of ____________________
☐ Diabetes, type ________________
☐ Thyroid Problems ____________
☐ Arthritis
☐ Lupus
☐ Mental Illness
☐ Personality Disorder __________
☐ Anxiety
☐ Kidney Disease
☐ Headache, non-migraine
☐ Asthma
☐ Chronic Lung Disease
☐ Osteoporosis
☐ Gallbladder Problems
☐ Liver Disease or Hepatitis
☐ Glaucoma
☐ Anemia
☐ Abuse, type ____________
☐ Weight Loss ____________
☐ ____

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Do you have to take antibiotics for dental procedures ____________________________________
Have you had trouble with anesthesia in the past?, explain _________________________________
Do you have dental caps, plates or dentures ____

Surgical History (type, date); *(example: appendix 2007; c-section 2003; gallbladder 1999; tonsils 1990)*

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Family History *(mother, father, siblings, aunts/uncles, grandparent)* ***Please note if maternal or paternal***

☐ Heart disease, *Who* ____________________
☐ High Cholesterol, *Who* __________________
☐ High Blood Pressure, *Who* ______________
☐ Blood Clotting Disorder, *Who* ___________
☐ Bleeding Disorder, *Who* ________________
☐ Anesthetic Problems, *Who* _____________
☐ Asthma, *Who* _________________________
☐ Kidney Disease, *Who* __________________
☐ Mental Illness, *Who* ___________________
☐ Lupus, *Who* ______________________________
☐ Stroke, *Who* ______________________________
☐ Diabetes, *Who* ____________________________
☐ Arthritis, *Who* _____________________________
☐ Cancer of Ovaries, *Who* ____________________
☐ Cancer of Breast, *Who* _____________________
☐ Cancer of Uterus, *Who* _____________________
☐ Cancer of Colon, *Who* ______________________
☐ Other Cancer, *Who/What* ___________________

I have answered this completely & to the best of my knowledge.

Signature ____ Date ____________________