

Kerry L. Gorsuch, MD
 Geron D. Turke, DO
 Kirsten L Anderson, MD
 Sejal P Bennett, MD
 Trisha L Zylstra, MD

Patient Medical Questionnaire

Name _____ Age _____ Today's Date _____

Have you been to this office before? _____ What is the reason for your visit today? _____

Date of your last period _____ How often are your periods? _____

How many pregnancies and deliveries have you had? _____

Do you have an Advanced Directive? _____ If so, please provide a copy to SM OB/GYN.

Are you taking any medications, vitamins or supplements? _____

If yes, please list: _____

Have you had any surgeries? _____ If yes, please list: _____

Do you have any other medical problems? If yes, please list: _____

Do you have problems at home? _____

Do you have a personal or family history of breast, colon, or ovarian cancer? If yes, please indicate which: _____

Do you smoke? _____ If yes, how much? _____

Do you drink alcohol? _____ If yes, how much? _____

Do you use illegal street drugs? _____ If yes, what type _____

Are you using anything for contraception? _____ If yes, what form? _____

Are you planning on getting pregnant within the next year? _____

ALLERGIES: _____ REACTIONS: _____

When was your last pap smear? _____

When was your last mammogram? _____

When was your last stool test? _____

When was your last cholesterol test? _____

When were your last immunizations (ie: Tetanus) _____ more than 10 yrs. _____ less than 10 yrs.

When was your last flu vaccine? _____ Given in our office or elsewhere? _____

When was your last pneumonia vaccine? _____ Given in our office or elsewhere? _____

Do you have problems with:

(Please circle Y for yes or N for No)

Abnormal or irregular bleeding?	Y	N	Chest pain or racing heart?	Y	N
Menstrual cramps or pelvic pain?	Y	N	Shortness of breath?	Y	N
Premenstrual headaches, moodiness?	Y	N	Visual Changes?	Y	N
Postmenopausal concerns?	Y	N	Numbness, tingling, or headaches?	Y	N
Vaginal discharge or vulvar irritation?	Y	N	Cough or wheezing?	Y	N
Urinary problems?	Y	N	Breast masses or discharge?	Y	N
Change in bowel habits or abdominal pain?	Y	N	Joint, muscle, or bone pain?	Y	N
Weight gain or loss?	Y	N	Skin lesions or rashes?	Y	N
Ear pain or hearing loss?	Y	N	Depression?	Y	N

Emergency Contact:

Name: _____ Relationship: _____

Home phone: _____ Work phone: _____

Patient's Date of Birth _____ Patient Signature _____

VITALS: BP _____ WT _____ HT _____ Temp _____ HR _____ BMI _____