Khan Obstetrics & Gynecology Associates, P.A.

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PATIENT QUESTIONNAIRE

If any of these questions do not apply to you, please mark those with "N/A."

Name: _____ Age: _____ Date: _____ Last Menstrual Period: _____

When was your last Pap Smear?: _____ Was it normal?: Yes No
When was your last Mammogram?: _____ Was it normal?: Yes No
When was your last Colonoscopy?: _____ Was it normal?: Yes No
When was your last Bone Density Test?: _____ Was it normal?: Yes No
When was the last time your Cholesterol was checked?: _____
Who is your primary care physician?: _____

Are your periods regular (about once a month)?: _____
Are they painful?: Yes No Are they heavy?: Yes No
How many days to they last?: _____
Have you gone through menopause?: Yes No How old were you?: _____
Have you had bleeding since menopause?: Yes No

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Are you sexually active?: Yes No
What do you use for contraception?: _____
Have you ever had (circle): Chlamydia Gonorrhea Syphilis Herpes HPV Genital Warts
Have you ever had an abnormal Pap Smear? Yes No If yes, in what year? _____
If yes, did you have any of the following procedures? (circle those that apply):

Colposcopy and Biopsy

Cryosurgery (freezing of the cervix)

LEEP (minor surgery to remove part of the cervix)

Cone Biopsy (minor surgery to remove part of the cervix)

How many times have you been pregnant?: ____ How many vaginal births?: ____ How many C-sections?: ___
How many miscarriages?: _____ How many abortions?: _____ How many ectopics?: _____

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Do you have any of the following medical problems? If so, when did symptoms first appear? Please circle and put date.

Diabetes
High Blood Pressure
Glaucoma
Hypothyroidism
Hyperthyroidism
History of Blood Clot in Leg or Lung
Depression
Asthma
Other _____

Osteoporosis
Osteopenia
High Cholesterol
Heart Disease
Mitral Valve Prolapse
Kidney Disease
Arthritis
Cancer – What type?: _____

Have you had (circle): Vaginal Hysterectomy | Abdominal Hysterectomy | Supracervical Hysterectomy | Laparoscopic Assisted Hysterectomy | Total Laparoscopic Hysterectomy | Both Ovaries Removed

Please list any other operations you have had:

_____ _____

_____ _____

Please list any medications you take regularly (prescription and/or non-prescription). It is not necessary to include dosages.

_____ _____

_____ _____

_____ _____

_____ _____

Please list drug allergies, or enter "none": _____

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Please list anyone in your family (parents, siblings, children, grandparents, aunts, uncles or cousins) with the following diseases:

Diabetes: _____

Heart Disease (e.g., heart attacks): _____

High Blood Pressure: _____

Osteoporosis: _____

Breast Cancer (including age at diagnosis): _____

Ovarian Cancer (including age at diagnosis): _____

Colon Cancer (including age at diagnosis): _____

Blood Clot in the Leg: _____ Blood Clot in the Lung: _____

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Do you smoke? Yes No If yes, how often?: _____ For how many years?: _____

How often do you drink alcohol, and how much do you drink?: _____

Do you use recreational drugs (e.g., marijuana, cocaine)?: _____

Please circle you current marital status: Single Married Separated Divorced Widowed Other Relationship

What is your occupation?: _____

Race: African American: _____ Asian: _____ Caucasian: ____ Hispanic: _____

Native American: _____ Pacific Islander: ____ Other: _____

********** End of questionnaire **********