BLESSINGS
Woman's Care & Medical Spa

7157 University Blvd., Winter Park, FL 32792 | (407) 571-9185

PATIENT QUESTIONNAIRE

NAME | MARITAL STATUS S M W D SEP | DATE OF BIRTH | DATE

REASON FOR VISIT?

SYSTEM REVIEW & FAMILY HISTORY

PLEASE CHECK (✔) IF YOU (PERS) OR ANY BLOOD RELATIVE (FAM) HAD ANY OF THE FOLLOWING CONDITIONS

	PERS	FAM
1. HEART DISEASE	☐	☐
2. HEADACHES/MIGRAINE	☐	
3. ABNORMAL PAP SMEARS	☐	
CERVICAL DYSPLASIA ☐		
4. HIGH BLOOD PRESSURE	☐	☐
5. HIGH CHOLESTEROL	☐	☐
6. RESPIRATORY DISEASE	☐	☐
PULMONARY (LUNG)		
7. BREAST DISEASE	☐	☐
8. JAUNDICE/HEPATITIS	☐	☐
9. HIATAL HERNIA (REFLUX)	☐	☐
10. PEPTIC ULCER (STOMACH)	☐	☐
11. BOWEL DISEASE	☐	☐
12. KIDNEY DISEASE	☐	☐
13. URINARY INCONTINENCE	☐	☐

	PERS	FAM
14. URINARY INFECTIONS	☐	
15. BLOOD TRANSFUSION	☐	
16. BLOOD DISORDER	☐	
17. PHLEBITIS	☐	
18. SKIN DISEASE	☐	☐
19. DIABETES	☐	☐
20. THYROID DISEASE	☐	☐
21. CANCER (TYPE)	☐	☐
(TYPE)	☐	☐
22. EPILEPSY/NEUROLOGICAL DIS	☐	☐
23. ARTHRITIS-JOINT PAIN	☐	☐
24. OSTEOPOROSIS	☐	☐
25. ANXIETY/DEPRESSION	☐	☐
26. SLEEP PROBLEMS	☐	☐

HOSPITAL ADMISSIONS

LIST THOSE OPERATIONS & SERIOUS ILLNESS' WHICH REQUIRED HOSPITALIZATION (EXCLUDING PREGNANCY)

YEAR	REASON FOR ADMISSION / HOSPITAL	YEAR	REASON FOR ADMISSION / HOSPITAL

MEDICATIONS

CURRENT MEDICATIONS AND DOSAGE

DRUG ALLERGIES

MENSTRUAL HISTORY

AGE AT FIRST PERIOD? | IF MENSTRUATING - DATE OF LAST PERIOD (1ST DAY)?

PERIOD INTERVAL ***NUMBER*** (1ST DAY TO 1ST DAY) - ***OF DAYS*** | DURATION OF BLEEDING? | CRAMPS Y N ☐ MILD ☐ SEVERE ☐ MOD. ☐ ALWAYS PRESENT | MEDICATIONS FOR CRAMPS Y N

HOW MANY PERIODS IN THE LAST YEAR? | BLEEDING (SPOTTING) BETWEEN PERIODS? Y N

VAGINAL INFECTIONS

HISTORY OF ☐ YEAST ☐ TRICHOMONAS ☐ CHLAMYDIA ☐ HERPES ☐ GONORRHEA ☐ BACTERIAL VAGINOSIS

PAP TEST

DATE OF LAST TEST | ☐ NORMAL ☐ ABNORMAL

MAMMOGRAM

DATE OF LAST TEST | ☐ NORMAL ☐ ABNORMAL

CONTRACEPTIVE HISTORY

CURRENT METHOD | IF PILL-BRAND | PAST METHODS

OBSTETRICAL HISTORY

NUMBER OF PREGNANCIES | PREMATURE BABIES | MISCARRIAGES | ABORTIONS | LIVING CHILDREN

BORN YEAR/MOS.	WEEKS PREG.	WT.	SEX	TYPE OF DELIVERY	REMARKS	BORN YEAR/MOS.	WEEKS PREG.	WT.	SEX	TYPE OF DELIVERY	REMARKS
1.						4.					
2.						5.					
3.						6.					

MENOPAUSAL HISTORY

IF APPLICABLE - HOT FLASHES Y N | TREATMENT-

SEXUAL HISTORY

☐ SATISFACTORY | ☐ WISH TO DISCUSS

SOCIAL HISTORY

SMOKING- CIG/DAY | # YEARS | **ALCOHOL-** OZ/WEEK | **COFFEE-** CUPS/DAY | **STREET DRUGS**