RETURN PATIENT QUESTIONAIRE

**Please fill out the form below. This information is part of your chart and will be kept confidential.*

Last Name: ________________________________ First Name: ___________________________ Middle Initial: ___________
Date: _______________ Date of birth: _______________________ Date of last exam: ___________
When did your last period start? ___________When did your previous period start? ___________
When did you have your first period? _____________ How many days pass between periods? ____________________________
How long are your periods? _______ How many pads/tampons do you use on your heaviest day? ________________________
Do you have spotting between periods? ☐ Yes ☐ No If Yes, when did this start? ______________________________
Do you take medications for menstrual cramps? ☐ Yes ☐ No If Yes, for how long have you taken this? __________________
What do you use for contraception? ___________________ For how long have you used it? _________________________
List any problems you have experienced with this contraceptive: ____
When was your last PAP smear? _______________________ What was the result? ___________________________________
Have you seen a doctor for any type of pelvic pain in the past year? ☐ Yes ☐ No If Yes, what was the cause? ______________
How was it treated?____
Have you tried to conceive in the past year? ☐ Yes ☐ No
Have you experienced any problems with intercourse in the past year? ☐ Yes ☐ No If Yes, please explain. _________________
____
Have you noticed any vaginal abnormalities (discharge, irritation lumps, sores, etc.)? ☐ Yes ☐ No If Yes, please explain. ____
____
Do you have hot flashes? ☐ Yes ☐ No If Yes, how often? ____
Do you perform monthly breast self-examinations? ☐ Yes ☐ No Have you had a breast biopsy or surgery? ☐ Yes ☐ No
When was your last mammogram? _________________ What was the result? ____

List members of your immediate family (parents, brothers, sisters, children) with:

	Relative (sister, uncle, etc.)	Maternal side	Paternal side	Age at Diagnosis	Deceased from this cancer? If yes, at what age?	Age Now
Breast Cancer						
Cervical Cancer						
Ovarian Cancer						
Endometriosis						
Uterine Cancer						
Other Cancer						
Diabetes						
Hypertension						
Heart Disease						
Psychiatric Disorder						
Kidney Disease						
Tuberculosis						
Respiratory Disease						

List any operations, when they were done, why they were done, and any complications: __________________________________
____
List any medications you take as well as dosages: ____
List any medications to which you are allergic:____
What is your occupation? __________ Do you use alcohol/tobacco/drugs? ☐ Yes ☐ No
What sources of stress do you have? ___________________________________ How often do you exercise? _________________
What are your eating habits? ___________________ How much caffeine do you consume in a day? ________________________
Do you have any medical conditions not previously mentioned? ____

Please check any of the following which have been recent concerns of yours:
☐ Fever ☐ Chills ☐ Fatigue ☐ Night sweats ☐ Weight change ☐ Sleep disturbance ☐ Injury ☐ Heat/cold intolerance

☐ Appetite ☐ Rash ☐ Skin lumps ☐ Skin color change ☐ Changes in nails/hair ☐ Nose bleeds ☐ Joint pain
☐ Muscle weakness ☐ Headaches ☐ Dizziness ☐ Visual changes ☐ Passing out ☐ Hearing loss ☐ Loss of smell
☐ Hoarse voice ☐ Bleeding gums ☐ Swelling in neck ☐ Thirst ☐ Frequent urination ☐ Body hair ☐ Painful respiration
☐ Shortness of breath ☐ Wheezing ☐ Asthma ☐ Cough ☐ Chest pain ☐ Swelling ☐ High blood pressure ☐ Heart attack
☐ Heart murmur ☐ Low blood iron ☐ Blood clots ☐ Free bleeding ☐ Blood transfusions ☐ Lupus ☐ Nausea ☐ Vomiting
☐ Sore tongue ☐ Diarrhea ☐ Gallstones ☐ Change in stool color ☐ Rectal bleeding ☐ Hemorrhoids ☐ Hepatitis
☐ Yellow skin/eyes ☐ Dark urine ☐ Constipation ☐ Painful urination ☐ Getting up at night to urinate ☐ Kidney stones
☐ Involuntary loss of urine ☐ Tremor ☐ Memory loss ☐ Speech changes ☐ Seizures ☐ Depression ☐ Mood changes
☐ Tension ☐ Suicidal thoughts ☐ Exposure to chemicals ☐ Radiation exposure ☐ Abdominal pain

Are you under the care of another physician? ____
Are there any issues you wish to discuss not previously mentioned? ____