HOUSTON WOMEN'S CARE ASSOCIATES
PATIENT QUESTIONNAIRE

Name: _____ Date: _____/___/_____
Age: _____ Marital Status: S / M Yrs – D / W
Occupation: _____ Referred by: _____

Reason for Today's Visit: _____
_____
_____

Pregnancies: ____ Deliveries: ____ Miscarriages: ____ Abortions: ____ Living Children: ____
What age did you begin having periods? _____ Last Menstrual Period: ___ / ___ / ____
How many days do you bleed? _____ How often do you have periods? _____
Any cramping with your periods?_____ Are your periods regular? _____
Do you consider your periods: Heavy _____ Moderate_____ or Light_____
Date of last PAP: ___ / ___ / ____ What method of contraception are you
Normal _____ Abnormal _____ currently using?_____
Have you ever had an abnormal PAP?_____ Which method(s) have you used in the
Date of last Mammogram: ___ / ___ / ____ past? _____
Normal: _____ Abnormal: _____ _____
Are you sexually active?_____ _____

History of Previous Surgeries:

	Date of Surgery:	Type of Surgery:
1.	___ / ___ / ____	_____
2.	___ / ___ / ____	_____
3.	___ / ___ / ____	_____
4.	___ / ___ / ____	_____
5.	___ / ___ / ____	_____

Please List Previous Pregnancies in Chronologic Order:

Year	Sex	Wt.	Hrs in Labor:	Anesthesia:	Complications:
____	____	____	____	_____	_____
____	____	____	____	_____	_____
____	____	____	____	_____	_____
____	____	____	____	_____	_____

List all medications currently used: _____ Do you smoke? Yes ___ No ___
_____ How many per day? _____
List all allergies to medications: _____ Do you drink alcohol? Yes ___ No ___
_____ If yes, number of drinks, beers, or
Do you exercise regularly? Yes ___ No ___ glasses of wine per week? _____
Are you in an abusive relationship? Yes ___ No ___ Do you use drugs? Yes ___ No ___
Do you have a history of eating disorders? Yes ___ No ___ Type? _____

Name: _____

Date: _____

Past Medical Problems:

	Self	Family
Birth Defects	____	____
Genetic Problems	____	____
Heart Disease	____	____
Hypertension	____	____
Diabetes	____	____
Migraine Headaches	____	____
Thyroid Problems	____	____
Cancer: Breast	____	____
Colon	____	____
Ovarian	____	____
Osteoporosis	____	____
Thrombophlebitis	____	____
Neurologic Disease	____	____
Asthma/Respiratory Disorders	____	____
Kidney/Urinary Tract Disorders	____	____
Gastrointestinal Disorders	____	____
Connective Tissue Disorders	____	____

Please Check Any Positive Response(s):

	Self
Blood Transfusions	____
Abnormal Bleeding	____
Tubal Pregnancy	____
Ovarian Cysts	____
Herpes	____
Gonorrhea	____
Chlamydia	____
HIV	____
PID	____

If You Are Pregnant, Do You Desire:

1. Information on permanent sterilization? _____
2. What type of anesthesia would you prefer? _____
3. Are you planning to: Breast Feed _____ Bottle Feed _____