

**HOUSTON WOMEN'S CARE ASSOCIATES  
PATIENT QUESTIONNAIRE**

---

Name: \_\_\_\_\_  
 Age: \_\_\_\_\_  
 Occupation: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Marital Status: S/M Yrs - D/W  
 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 currently using? _____	
Normal _____ Abnormal _____				
Have you ever had an abnormal PAP? _____			Which method(s) have you used in the past? _____	
Date of last Mammogram: ____/____/____			_____	
Normal: _____ Abnormal: _____				
Are you sexually active? _____				

---

**History of Previous Surgeries:**

	<u>Date of Surgery:</u>	<u>Type of Surgery:</u>
1.	____/____/____	_____
2.	____/____/____	_____
3.	____/____/____	_____
4.	____/____/____	_____
5.	____/____/____	_____

---

**Please List Previous Pregnancies in Chronologic Order:**

<u>Year</u>	<u>Sex</u>	<u>Wt.</u>	<u>Hrs in Labor:</u>	<u>Anesthesia:</u>	<u>Complications:</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

---

List all medications currently used: \_\_\_\_\_  
 \_\_\_\_\_

List all allergies to medications: \_\_\_\_\_  
 \_\_\_\_\_

Do you exercise regularly? Yes \_\_\_ No \_\_\_

Are you in an abusive relationship? Yes \_\_\_ No \_\_\_

Do you have a history of eating disorders? Yes \_\_\_ No \_\_\_

Do you smoke? Yes \_\_\_ No \_\_\_

How many per day? \_\_\_\_\_

Do you drink alcohol? Yes \_\_\_ No \_\_\_

If yes, number of drinks, beers, or glasses of wine per week? \_\_\_\_\_

Do you use drugs? Yes \_\_\_ No \_\_\_

Type? \_\_\_\_\_

Name: \_\_\_\_\_

Date: \_\_\_\_\_

---

**Past Medical Problems:**

Please Check Any Positive Response(s):

	<u>Self</u>	<u>Family</u>
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	_____	_____

	<u>Self</u>
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 \_\_\_\_\_