

Harbor Medical Group, Inc.
PATIENT HEALTH QUESTIONNAIRE

Name _____ Phone # (work) _____

Occupation _____ Phone # (home) _____

Age _____ # of Children _____ # of Miscarriages _____ # of Abortions _____

Are you sexually active? _____ Married? _____ Stable partner? _____

Family planning method _____

Do you have any family history of cancer of breast, colon, ovary, uterus or other? Please circle and describe _____

Do you have any family history of hypertension or diabetes? _____

Other illness? _____

Last menstrual period _____ Any problem with periods? (pain, heavy flow, irregularity) _____

Do you lose urine? _____ Have pain with urination? _____

Do you have any problems with sex? _____

Have you had any medical illness since your last visit? Surgeries? _____

Any problem with heart, lungs, kidneys, liver, blood, bladder, bowels, skin, high blood pressure, headaches, other? (circle and describe) _____

Any past problem with pap smears? (colposcopy, cryotherapy, laser therapy) _____

Any problem with your breasts? _____

Do you smoke? _____ Do you use recreational drugs or drink alcohol? (how much and how often?) _____

Take any medications? (list) _____

Exercise? _____ Eat a healthy diet? _____

Have you ever had syphilis, gonorrhea, herpes, venereal warts, condyloma, or PID, problems with your ovaries, or tubes, infertility, DES exposure, endometriosis or chronic pelvic pain? (circle and describe) _____

Are you allergic to any medications? _____

PSYCHOLOGICAL PROFILE:

<u>Depression</u>	<u>STRESS</u>	<u>COPING</u>	<u>SUPPORT</u>
_____	_____ Mild	_____ Good	_____ Good
Anxiety _____	_____ Moderate	_____ Adequate	_____ Adequate
Poor Sleep _____	_____ Severe	_____ Poor	_____ Poor
Poor concentration _____			
Other? _____			

Do you have a history of sexual abuse or trauma? _____

Have you had a mammogram? _____ Have you had a cholesterol check? _____

Do you have any vaginal itching, burning, or abnormal discharge today? _____

DO YOU HAVE ANY OTHER QUESTIONS TODAY? _____

