OFFICE USE ONLY:

DR._____

Wt._____ Ht._____

BP_____

Lakeside Doctors
Gynecology & Obstetrics

Annual Questionnaire

Please use **BLACK INK only**

Patient Questionnaire

1. Name_____ Date _____

2. Reason for this visit: _____

3. Preferred phone number: _____

4. Pharmacy and Address: _____ Pharmacy Phone_____

5. Primary Care Physician: _____ Address: _____ Phone: _____

Current Medications (Please list all medications, supplements and vitamins)

Medication	Dose	Frequency

Are you allergic to any medications? ☐ No ☐ Yes List Medicine and Reaction: _____

_____

Vaccination History

TDAP	☐ NO	☐ YES	If yes, Date of Vaccination: _____
COVID	☐ NO	☐ YES	If yes, Date of Vaccination: _____
Pneumonia	☐ NO	☐ YES	If yes, Date of Vaccination: _____
Gardasil (HPV)	☐ NO	☐ YES	If yes, Date of Vaccination: _____
Shingles	☐ NO	☐ YES	If yes, Date of Vaccination: _____
Flu	☐ NO	☐ YES	If yes, Date of Vaccination: _____

Menstrual History

1. Age of first period: _____ **2.** Do you have monthly periods? ☐ NO ☐ YES **3.** Do you have cramps? ☐ NO ☐ YES

4. If your menstrual periods are regular; periods start every _____ days

5. If your menstrual periods are irregular; periods start every _____ to_____ days (e.g., 12 to 60)

6. First day of last menstrual period: _____ (m/d/year) **7.** Is your period flow: ☐ Light ☐ Moderate ☐ Heavy

8. If postmenopausal, at what age: _____

Pap Smear/ Bone Density/ Mammogram/ Colonoscopy History

1. Date of last pap smear: _____ **2.** Have you had treatment for abnormal pap smears? ☐ NO ☐ YES

3. Have you had any of the following for abnormal pap:

Cryotherapy? If so, when? _____ Laser? If so, when? _____

Cone Biopsy? If so, when? _____ Loop Excision (LEEP)? If so, when? _____

4. Have you had a Mammogram? ☐ NO ☐ YES Date: _____ Result: _____ Location: _____

5. Have you had a Bone Density? ☐ NO ☐ YES Date: _____ Result: _____ Location: _____

6. Have you had a Colonoscopy? ☐ NO ☐ YES Date: _____Result: _____Location: _____

Past Medical History/Family History

Please list any surgeries, deliveries, or changes to family history since last visit: _____

_____

_____

Social History

1. Marital Status: (Circle One) Single Married Long Term Relationship Divorced Widowed

2. Preferred Pronouns: (Circle One) She/Her He/Him They/Them

3. Do You Smoke: ☐ NO ☐ YES _____packs/day ☐ Former Smoker _____ packs/day _____ years

4. Occupation: _____ **5.** Religion: _____

6. Stress Level: (Circle one) ☐ Low ☐ Medium ☐ High

7. Diet: Regular Vegetarian Other: _____

8. Exercise: Type: _____ How Often: _____

9. Sexual Orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual

10. Do you have sex with: ☐ Men ☐ Women ☐ Both

11. Sexually Active? ☐ NO ☐ YES

12. Has there been a new sexual partner in the last year? ☐ NO ☐ YES

13. Is sexual intercourse painful? ☐ NO ☐ YES

14. Current Birth Control Method: _____

15. Do You Drink Alcohol: ☐ NO ☐ YES How Many Drinks/Week? _____

16. Caffeine Intake: (circle one) None Occasional Moderate Heavy

17. Do You Use Illicit Drugs: ☐ NO ☐ YES Type _____Last Used _____

18. Number of Hours of Sleep Each Night: _____hrs.

Review of Systems

Please circle any problems you are having: or ☐ NO COMPLAINTS AT THIS TIME

Constitutional: ☐ NO COMPLAINTS

- fever, fatigue, significant weight loss (____lbs.), significant weight gain (_____lbs.)
- **Additional information**:_____

Cardiovascular: ☐ NO COMPLAINTS

- chest pain, irregular heartbeat, difficulty breathing
- **Additional information**:_____

Gastrointestinal: ☐ NO COMPLAINTS

- heartburn, difficulty swallowing, nausea, vomiting, abdominal pain, bowel movement changes, diarrhea, constipation, rectal bleeding
  Additional information: _____

Genitourinary: ☐ NO COMPLAINTS

- blood in urine, abnormal bleeding, flank pain, trouble urinating, urinary frequency, urinary urgency, painful urination, frequent urination at night, incontinence, rash, lesion, discharge, vaginal odor, vaginal itching
  Additional information: _____

Endocrine: ☐ NO COMPLAINTS

- thyroid disease, type 2 diabetes
- **Additional information**: _____

Menstrual: ☐ NO COMPLAINTS ☐ Currently No Period Due To: _____

- irregular timing, light flow, heavy flow, severe cramping, mood swings, irritability, tension/anxiety, depressed mood, breast pain/tenderness, bloating, feeling out of control/overwhelmed
  Additional information: _____

Menopausal: ☐ NO COMPLAINTS

- hot flashes, night sweats, vaginal dryness, memory loss, difficulty concentrating
- **Additional information**:_____

Sexual: ☐ NO COMPLAINTS

- decreased sex drive, painful intercourse, vaginal tightness, vaginal discomfort, bleeding w/ intercourse
- **Additional information**: _____

Psych: ☐ NO COMPLAINTS

- depression, anxiety, alcoholism, sleep disturbances, not situational, chronic, not chronic
- **Additional information**: _____

Breast: ☐ NO COMPLAINTS

- breast lump, breast mass, nipple discharge, skin changes, breast pain ☐ LEFT ☐ RIGHT
- **Additional information**: _____

Pain: ☐ NO COMPLAINTS

- chronic pain: neck, back, joint, other
- **Additional information**: _____