PATIENT QUESTIONNAIRE

Date:_____________

Name: ____ Age: ____________

Partner: ____ Age: ____________

Reason For Visit Today:

____

Past History of Medical Diseases:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

Surgeries:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

Last menstrual period (LMP): _____________ Age of first menstruation: ________

How often do you get your period: Every _______ days.

How many days of bleeding: ________

Cramping / pain = Severe _____ Moderate _____ Mild _____ When _______________

Medications presently using and used within the past year: ________________________

____

Allergies to medications: You:________________ Your partner:_________________

_________________ ___________________

PREGNANCY HISTORY

		Month/Year	Comments
# Times Pregnant	_____	____________________	__________________
# Full Term Births	_____	____________________	__________________
# Still Births	_____	____________________	__________________
# Premature Births	_____	____________________	__________________
# Miscarriages	_____	____________________	__________________
# Induced Abortions	_____	____________________	__________________
# Ectopic / Tubal	_____	____________________	__________________

Types of deliveries: Vaginal ___________________ Cesarean ________________

Pregnancy complications: (explain) ____

____

Are You:

1. Born in (please circle): USA Asia Africa Latin America Caribbean Eastern Europe Western Europe
2. Adopted? Yes No
3. Bisexual? Yes No
4. Do you drink alcohol? Yes No
   If yes, do you drink: Daily _____ Weekly _____ Occasionally _____
   Amount consumed: ________________
5. Do you smoke? Yes No If yes, amount daily: ______________

(Over Please)

In the past 12 months, have you and/or your partner ever: (Check if YES)	You	Your Partner	When	Result
1. Had a TB skin test?	( )	( )	__________	_________
2. Been exposed to a person with active TB?	( )	( )	__________	_________
3. Been outside the US or Canada?	( )	( )	__________	_________
4. Been under a doctor's care or had a major illness or surgery?	( )	( )	__________	_________
5. Had any shots or vaccines?	( )	( )	__________	_________
6. Had contact with anyone who has had hepatitis?	( )	( )	__________	_________
7. Had a tattoo, ear or body piercing, acupuncture, or accidental needle stick?	( )	( )	__________	_________
8. Been a health care worker who has had significant exposure to blood or body fluids containing blood?	( )	( )	__________	_________
9. Been treated for syphilis, gonorrhea, or herpes?	( )	( )	__________	_________

Have you and / or your partner ever: (Check if YES)

	You	Your Partner	When	Result
1. Ever smoked? (please circle) Cigarettes Marijuana	( )	( )	__________	_________
2. Had a past positive TB skin test?	( )	( )	__________	_________
3. Had HIV infection or AIDS?	( )	( )	__________	_________
4. Had silicosis?	( )	( )	__________	_________
5. Suffered from malnourishment?	( )	( )	__________	_________
6. Undergone prolonged steroid treatment?	( )	( )	__________	_________
7. Abused IV drugs?	( )	( )	__________	_________
8. Suffered from immunosuppression?	( )	( )	__________	_________
9. Had diabetes?	( )	( )	__________	_________
10. Suffered from alcoholism?	( )	( )	__________	_________
11. Been obese?	( )	( )	__________	_________
12. Had a thyroid disease?	( )	( )	__________	_________
13. Used an IUD?	( )	( )	__________	_________
14. Had genetic problems?	( )	( )	__________	_________
15. Have you or any of your blood relatives had Creutzfeldt-Jakob Disease (CJD), or have you ever been told that your family is at increased risk for CJD?	( )	( )	__________	_________
16. Been refused as a blood donor?	( )	( )	__________	_________
17. Had a life threatening allergic reaction to a medication?	( )	( )	__________	_________
18. Had any heart conditions, heart attack, chest pain, or shortness of breath?	( )	( )	__________	_________
19. Had lung, kidney, liver, or blood diseases?	( )	( )	__________	_________
20. Fainted, lost consciousness, had convulsions, or epilepsy?	( )	( )	__________	_________
21. Had cancer or another serious illness?	( )	( )	__________	_________
22. Received human pituitary derived growth hormone injections?	( )	( )	__________	_________
23. Received a dura mater graft (brain tissue)?	( )	( )	__________	_________
24. Received blood or blood products, bone grafts, organ, or other tissue transplants?	( )	( )	__________	_________
25. Had dialysis or been in contact with someone on dialysis?	( )	( )	__________	_________
26. Had hepatitis, yellow jaundice, or a positive hepatitis test?	( )	( )	__________	_________
27. Taken the drug Tegison for psoriasis?	( )	( )	__________	_________
28. Had Chagas' disease, babesiosis, or malaria?	( )	( )	__________	_________
29. Ever taken clotting factor concentrates for a bleeding disorder?	( )	( )	__________	_________

Have you, your partner or any member of your family, or your partner's family had a problem or defect at birth of any of the following body systems:

	You	Your Partner	When	Result
1. Organ (heart, lung, kidney, etc)?	( )	( )	__________	_________
2. Blood circulation?	( )	( )	__________	_________
3. Respiratory system?	( )	( )	__________	_________
4. Gastrointestinal system?	( )	( )	__________	_________
5. Genitourinary?	( )	( )	__________	_________
6. Metabolic (hormones, enzymes, etc.)?	( )	( )	__________	_________
7. Nervous system, brain, spinal cord?	( )	( )	__________	_________
8. Bones, muscles, joints, limbs?	( )	( )	__________	_________

Other: ____

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