Current Patient Questionnaire

CWC Div 22 – Band, Tyau, Sine, Resta, Lizardo, Shrout, Hersh

Today's Date: _____ **Reason for Visit:** _____

Patient Name: _____ **Date of Birth:** _____
Last First MI

Name of Pharmacy: _____ Phone: _____

Pharmacy Address: _____

Last Menstrual Period _____ **Last Pap smear** _____ **Dexa Scan** _____
Last Mammogram _____ **Breast Self Exam** Yes or No **Colonoscopy** _____
Contraception Method _____ **Hysterectomy Yes** or No
Past Obstetrical History
Full term _____ Premature _____ Abortions _____ Miscarriages _____ Living Children _____ Ectopic _____

1) Have you had **any changes** to your medical history since your last visit at this office? Yes or No. If yes, please explain:

_____

_____

2) Have you had any **surgeries** or **hospitalizations** or any **new medical diagnoses** since your last visit with us? Yes or No. If yes, Please list and date:

_____

_____

3) Have there been any changes in your **family history** since your last annual visit with our practice? Yes or No. If yes, please explain:

_____

_____

4) **Current Medications**

Name of Drug

5) **Allergies**

Type of Allergy	Reaction

Social History (put type and amount) _____

Tobacco: ☐ Yes ☐ No _____ Alcohol: ☐ Yes ☐ No _____ Caffeine: ☐ Yes ☐ No _____

Do you feel safe in your current environment? Yes or No
Are you experiencing any type of pain today? Yes or No

_____ Signature of patient or guardian of minor