



WILLIAMSON
HEALTH

Women's Group of Franklin

Patient Questionnaire

Name: _____ DOB: _____ Date: _____

Age: _____ Currently pregnant? ☐ Yes ☐ No Trying to get pregnant? ☐ Yes ☐ No

of pregnancies: _____ # of miscarriages: _____ # of abortions: _____ # of live births: _____

Referred by: _____

Reason for today's visit: _____

First day of last menstrual period: _____ Current method of birth control: _____

Menstrual flow: _____ days between periods _____ days of flow

Date of last Pap smear: _____ Any history of abnormal Paps?: _____

Date of last mammogram: _____

Medical history: Please list any medical problems.

Surgical history: Please list any past surgeries with dates.

Medications: Please list all medications including vitamins, herbs, and over-the-counter drugs.

Allergies: Please list all drug allergies and the reaction you have with them.

Family history: Please list any medical conditions in your family including the family member who has the problem (for example: breast cancer grandmother; diabetes sister, brother).

Social History: Have you ever smoked? _____ How much? _____ Have you ever vaped? _____ How much? _____
Drink alcohol? _____ How much? _____ Other substance use? _____

Occupation: _____

PLEASE TURN PAGE OVER FOR MORE INFORMATION



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Patient Questionnaire

Name: _____

Are you currently having any of the following problems? Please check all that apply.

- | | | |
|---|--|---|
| ☐ Skipping Periods | ☐ Appetite Loss | ☐ Numbness |
| ☐ Heavy Periods | ☐ Sore Throat | ☐ Weakness |
| ☐ Painful Periods | ☐ Nosebleeds | ☐ Agitation |
| ☐ Pelvic Pain | ☐ Runny Nose | ☐ Confusion |
| ☐ Pain with Intercourse | ☐ Eye Pain | ☐ Depression |
| ☐ Vaginal Discharge | ☐ Visual Changes | ☐ Hostility |
| ☐ Exposure to Sexually Transmitted Disease | ☐ Hearing Loss | ☐ Suicidal Thoughts |
| ☐ Excessive Hair Growth | ☐ Shortness of Breath | ☐ Excessive Bleeding from Cuts |
| ☐ Hot Flashes | ☐ Cough | ☐ Swollen Lymph Nodes |
| ☐ Pain with Urination | ☐ Pain with Breathing | ☐ Asthma |
| ☐ Frequent Urination | ☐ Nausea | ☐ Seasonal Allergies |
| ☐ Involuntary Loss of Urine | ☐ Diarrhea | ☐ Bronchitis |
| ☐ Sexual Assault or Abuse | ☐ Painful Bowel Movements | ☐ Chest Pain |
| ☐ Breast Mass | ☐ Vomiting | ☐ Irregular Heart Beat |
| ☐ Painful Breast | ☐ Constipation | ☐ Leg Swelling |
| ☐ Nipple Discharge | ☐ Bloating | ☐ Muscle Pain |
| ☐ Fever | ☐ Skin Rash | ☐ Arthritis |
| ☐ Weight Loss | ☐ Swelling | ☐ Swollen Joints |
| ☐ Dizziness | ☐ Bruising | |
| ☐ Fatigue | ☐ Cuts | |
| | ☐ Headaches | |