HENDERSON & WALTON WOMEN'S CENTER, P.C. **ANNUAL PATIENT QUESTIONNAIRE**

NAME ____ **AGE** ______ **DATE** _______________________________

Please list current medications including dosage and frequency:

NAME OF MEDICATION	DOSAGE	FREQUENCY TAKEN

SEASONAL VACCINES THIS YEAR ☐ Pneumonia ☐ FLU **HAVE YOU EVER HAD THESE VACCINES?** ☐ SHINGLES ☐ TDAP ☐ Gardasil

PLEASE LIST ANY/ALL DRUG ALLERGIES: ____

LIST ANY CHANGES IN YOUR FAMILY MEDICAL HISTORY ____

CHANGES IN YOUR PERSONAL LIFE ____

HAVE YOU BEEN DIAGNOSED WITH ANY CHRONIC ILLNESSES (check all that apply)

☐ Heart Disease ☐ Genetic Disorder ☐ Alcohol Use: ____ Socially ____ Rarely ____ Frequently

☐ Diabetes ☐ Seizure Disorder ☐ Drug Use ☐ Smoking

☐ Lung Disease ☐ Anemia ☐ Mental Illness ☐ Hypertension

☐ Kidney Disease ☐ Other ____

☐ Sexually Transmitted Disease

Since your last visit, have you:
Had surgery? ☐ Yes ☐ No ***If yes, approx. type and date of surgery***______________________________

Been diagnosed or treated for a new illness/injury? ☐ Yes ☐ No ***If yes, please describe***

____

____

Are you sexually active? ☐ Yes ☐ No ☐ Never **Last Menstrual Cycle?** ___________________________

What method of birth control do you *currently* use? Check *all* that apply:

☐ Pills ☐ Patch ☐ Ring ☐ Condom ☐ IUD ☐ Tubes Tied ☐ Nothing

☐ Essure ☐ Spermicide ☐ Withdrawal ☐ Timing ☐ Shot ☐ Vasectomy

PATIENT SIGNATURE: ____ __________________________ **RN/CA**