AdventHealth Medical Group

HEALTH QUESTIONAIRE

Julie Schneider, MD, FACOG, FPMRS - UROGYNECOLOGY

Name: _____ Date of Visit: _____

Age: _____ Date of Birth: _____

Preferred Lab: _____ **Preferred Imaging Center**: _____

Preferred Pharmacy: _____ Present Menstrual Cycle: ❒ Regular ❒ Irregular

Do you have to be pre-medicated for procedures? Y / N Name of pre-medication: _____

First day of your last **normal** menstrual period: _____ Date of last PAP smear: _____

Number of Pregnancies: _____ Number of living children: _____

Primary Care Physician _____

1. **Reason for visit, please state:** _____
   _____
2. Current medications (Please list): _____
   _____
3. Allergies to medications: _____
4. Are you sexually active? ❒ Yes ❒ No If yes, with ❒ Male ❒ Female
   If yes, ❒ monogamous (one partner) for _____ ❒ months / ❒ years; ❒ not monogamous
   If yes, pregnancy prevention? ❒Pills ❒Condoms ❒Diaphragm ❒Depo-Provera Shots ❒Withdrawal method ❒Vasectomy ❒Tubal ligation (tubes tied)
   Circle: **Y** (Yes) **N** (No)
5. Y / N Does anyone in your family have a history of: *(Please check)*
   ❒Breast Cancer ❒Ovarian Cancer ❒Uterus Cancer ❒Colon Cancer ❒Osteoporosis ❒Blood clots requiring blood thinners
6. Y / N Have you ever had a blood clot in your legs or lungs and placed on blood thinners?
7. Y / N Do you want information on domestic violence?
8. Y / N Any history of a sexually transmitted disease? ❒Herpes ❒Chlamydia ❒Gonorrhea ❒Trichomoniasis ❒HPV ❒Syphilis ❒Other_____
9. Y / N Any history of an abnormal PAP with pre-cancer (dysplasia) or cancer?
   If yes, when, _____ Treatment: _____
10. Y / N Do you use tobacco products? If yes, _____ pack(s) per day
11. Y / N Do you use alcohol products? If yes, _____ drink(s) per ❒day ❒ week ❒ month
12. Y / N Do you use illegal/recreational drugs?
13. Y / N Have you ever had any surgery? If yes, PLEASE LIST: _____
    _____
14. Y / N Any chronic (long-term) medical problems that you may be taking medication for? If yes, PLEASE LIST:
    _____
    _____
15. Y / N If you are over 40, have you had a baseline mammogram this year? If yes, when? _____
16. Y / N If you are 50 or older, have you ever had a sigmoidoscopy/colonoscopy? If yes, when? _____
17. Y / N Have you completed an Advance Directive Will? *(Living Will)*
18. Y / N Do you have religious beliefs that influence your medical decisions?
19. Y / N Do you have someone who loves and cares for you?
20. Y / N Do you have a source of joy in your life?
21. Y / N Do you have a sense of peace today?

I understand the above information is necessary to provide me with medical care in a safe and efficient manner.
I have answered all questions to the best of my knowledge and will notify the doctor of any changes.

Patient Signature: _____ Reviewed/Doctor's Signature: _____

Julie D. Schneider, MD, FACOG, FPMRS