eimc ENDOBIOGENIC INTEGRATIVE MEDICAL CENTER

Women's Preventive Screening Questionnaire

Name:		Date of Birth	
Home Address:			
Primary Phone:		E-mail address	
Emergency Contact Name and phone #:		Relationship	
Primary health care provider:			

Gynecologic/Endocrine History

Date of last menstrual period		Was it normal?	Yes ___	No ___

Age of first menses		Days between menses(from first day to first day)	

Length of flow		Amount of Flow:	Heavy ___	Medium ___	Light ___

Do you have any of the following symptoms? (*Check box to right of symptom*)

Premenstrual discomfort		Abnormal vaginal discharge		Blood clots in legs or lungs		Fever, chills, or sweats	
Premenstrual mood disturbance		Abdominal pain		Low sexual interest		Dry skin or Brittle nails	
Heavy menses		Pain with urination		Pain with intercourse		Excess body hair	
Bleeding between periods		Bladder control problems		Difficulty with orgasm		New moles or rashes	
Bad menstrual cramps		Fatigue		Teeth grinding		Hair loss	
Breast pain		Weight gain		Memory disturbance		Acne	
Genital pain		Weight loss		Depression or anxiety		Body aches	

Current form of Contraception (if applicable)

Abstinence ___	IUD ___	Pills ___	Shot ___	Patch ___	Implant___
Condoms ___	Diaphragm___	Rhythm ___	Tubes tied ___	Vasectomy ___	Menopause ___

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Obstetric/Postpartum History

Have you ever been pregnant?	Yes ___	No ___	How many babies have you had?			
Any complications of delivery?	C-section ___	Laceration (tear) ___	Infection ___	Hemorrhage ___		
Dates of deliveries:						
Number of miscarriages	0 ___	1 ___	2 ___	≥3 ___		
Did you breast-feed your babies?	No ___	Yes <3 months ___	Yes >3 months ___			

Menopause (skip if not applicable)

Age of menopause		Natural ___	Surgical ___	
Current menopausal symptoms	Hot flashes ___	Insomnia ___	Night sweats ___	Memory problems ___
	Depressioin ___	Anxiety ___	Achiness ___	Vaginal dryness ___

Past Medical History

Chronic medical problems: (List below)	Date of onset	Medications you are now taking for this problem		Hospitalizations: (Reason below)	Date
List other herbs and medications you are taking:→	Since when?	List any drug allergies below:		Surgeries (List below)	Date
				Ever transfused? Yes __ No __	

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Preventive Screening History

Date of last pap	→	Result: →	Normal ___	Abnormal ___
Ever had abnormal pap?	Yes ___ No ____			
Ever treated for cervical dysplasia?	Yes ___ No ____			
Ever treated for sexually transmitted infection?	Yes ___ No ___			
Ever treated for uterine infection?	Yes ___ No ___			
Cholesterol level	Never checked ___	Normal ___	A little high ___	Quite high ___
Triglyceride level	Never checked ___	Normal ___	A little high ___	Quite high ___
If over 40 date of last mammogram		Result:	Normal ___	Abnormal ___
If over 50 date of last colonoscopy		Result:	Normal ___	Abnormal ___

Lifestyle and Habits

Do you use tobacco?	Yes ___ No ___	How much?		
Do you drink alcohol?	Yes ___ No ___	How much?		
Do you use recreational drugs?	Yes ___ No ___	What kind?		
Are you on any special diet?	Vegetarian ___	Low Carb ___	Low fat ___	Low Cal ___
Exercise per week:	None ___	1-3 hours ___	4-6 hours ___	>6 hours ___
Type(s) of exercise:				
General mental stress level:	Low stress ___	Moderate stress ___	High stress ___	
Current Occupation(s):				
Relationships				
How long have you been with your current partner?		Number of previous partners:		
Sexual preference:	Heterosexual ____	Bisexual ___	Lesbian ___	Asexual ___
Do you feel safe in your current relationship?	Always ___	Usually ___	Rarely ___	Never ___
Have you or your partner(s) ever used IV drugs?	Yes ___	No ___	Don't know for sure ___	

Family History: Mark box to right if any history in first or second degree blood relatives of:

Blood clots to legs or lungs		Liver problems		Kidney disease	
Cancer		Dementia		Heart disease	
Diabetes		Depression		Hypertension	
Arthritis		Stroke		Seizures	

Patient signature: ____ **Date:** __________________
Reviewed by: ____ **Date:** __________________