63 W. Sunbridge Rd.
Fayetteville, AR 72703
582-FEMM (3366) Fax: 479-582-5843
www.renaissancewomenshealth.com

New Patient Health Questionnaire
40 years old or older

Name ______________________________ Date of Birth _________ Age ______

Primary Care Physician ______________________________

ALLERGIES: (include reaction i.e. rash, breathing problems)

____

____

MEDICATIONS AND DOSAGES: Include vitamins, minerals and herbals supplements.

____

____

HEALTH MAINTENANCE: Have you ever had any of the tests/vaccines listed below? When and what was the result?

	Month/ Year	*Results*	*Treatments*
Pap test (any abnormal paps)			
Mammogram			
Colonoscopy			
DEXA (bone density test)			
Cholesterol test			
Adult screening labs			
Tetanus-diphtheria booster			

SURGERIES: Include dates

____

____

MAJOR ACCIDENTS OR INJURIES/HOSPITALIZATIONS – include dates

____

____

___ When was the first day of your **last menstrual period**?
___ How many times have you been pregnant?
___ Number of living children
___ Number of Vaginal Deliveries ___ C-sections
___ How old were you when you started your periods?
___ How often are your periods?
___ How long do you bleed?
___ Are you having problems with your periods?
If yes, explain______________________
___ Are you sexually active?
___ What method of birth control are you using?

___ Are you having any **sexual concerns**?
___ Are you worried about **exposure to STDs**?
___ Are you having problems with **pelvic pain**?
___ Are you having frequent or **painful urination**?
___ Do you have any abnormal **vaginal discharge**?
___ Do you have any abnormal **vaginal itching**?
___ Are you having problems with **urine leakage**?
___ Do you smoke? __________
How many a day? ______________ per day
For how long?______________________
___ Do you use alcohol or drugs? ______________
How often?______________________

WHAT ARE YOUR CONCERNS?

____

____

63 W. Sunbridge Rd.
Fayetteville, AR 72703
582-FEMM (3366) Fax: 479-582-5843
www.renaissancewomenshealth.com

Name ____ Date of Birth___________________

Check and date squares below for you and close family members who had any of these diagnoses.
If they pertain to you please list date and treatment for condition.

Diagnosis	Self	Mother	Father	Brother	Sister	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Alzheimer's									
Asthma									
Alcoholism									
Blood Disease									
Heart Disease									
Cancer									
Brest									
Ovarian									
Other									
Stroke									
Depression									
Developmental delay									
Diabetes									
Hearing Problems									
High Cholesterol									
Mental Illness									
Migraines									
Obesity									
Lung Disease									
Kidney Disease									
Seizure Disorder									
Sickle Cell									
Thyroid Disease									
Breast Disease									
Inherited Disease									
HIV/AIDS									
Blood Clots									
Bleeding problems									
Varicose veins									
Gallbladder problem									
Sexually Transmitted Diseases									
Hepatitis/jaundice									
Headache, chronic									
Fibroids									
Endometriosis									
Bladder problems									
Urinary Tract Infection									

Patient Health History. Explain above marked diagnoses and any additional problems.

____

____

____