RENAISSANCE WOMEN'S HEALTHCARE
A MANA CLINIC

New Patient Health Questionnaire
Less than 40 years old

mana medical associates

Name _____ Date _____

Date of Birth _____ Age _____ Primary Care Physician _____ Pharmacy _____

Married __ Single __ Divorced __ Partnered __ *Partner M or F* Employer _____ Job Title _____

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			
Rubella Antibody Test			
Chicken Pox or the vaccine			
Tetanus-diphtheria booster			
Hepatitis B Vaccine			
Cholesterol test			
Gardasil (HPV Vaccine)			

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
___ Number of Abortions
___ Number of Miscarriages
___ How old were you when you started your periods?
___ How often are your periods?
___ How long do you bleed?
Flow of period ___ Light ___ Moderate ___ Heavy
___ 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**?
___ Have you ever had an STD? Type _____ When _____
___ 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?
☐Current Smoker-Everyday (indicate how much) _____
☐Current Smoker-occasional_____ ☐Former Smoker
☐Never Smoked ☐Smoker-current status unknown ☐Unknown if ever smoked
___ Do you use alcohol or drugs? _____
How often?_____

WHAT ARE YOUR CONCERNS? _____

_____

Name _____ Date of Birth _____

Please check and date the squares below for you and close family members who had any of these diagnoses.

Diagnosis	Self	Mother	Father	Brother	Sister	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Alzheimer's									
Alcoholism									
Asthma									
Bladder problems									
Blood Clotting Disorders									
Blood Clots in Legs (DVT)									
Cancer									
Breast									
Cervical									
Colon									
Ovarian									
Uterine									
Other									
Depression									
Developmental delay									
Diabetes									
Endometriosis									
Fibroids									
Gallbladder prob.									
Headache, chronic									
Heart Disease									
Hepatitis/ jaundice									
High Blood Pressure									
High Cholesterol									
HIV / AIDS									
Inherited Disease									
Kidney Disease									
Liver disease									
Lung Disease									
Mental Illness									
Migraines (with or without Aura)									
Obesity									
PCOS									
Seizure Disorder									
Sickle Cell									
Stroke									
Thyroid Disease									
Alzheimer's									

If they pertain to you, please list date and treatment for condition below. Explain above marked diagnoses and any additional problems.

_____

_____

_____