

MERIDIAN WOMEN'S HEALTH
PATIENT HEALTH QUESTIONNAIRE - UPDATE

Name _____
 (please print)
 Date _____ Age _____

Problems to discuss today _____

Operations / Hospitalizations: Anything new since your last visit? _____

Current Medications/Vitamins _____

Allergies to Medications: Anything New? _____

Family History: Changes in the health of father, mother, brother, sisters, children _____

First day of last menstrual period _____

Date of last Pap smear _____

Date of last mammogram _____

History of blood transfusion? _____

Date of last cholesterol screening _____

Date of last sigmoidoscopy / colonoscopy _____

Are your periods regular? _____

Are you sexually active? _____

Birth control method currently used: _____

If menopausal, are you on hormone replacement? _____ Hormones used: _____

New sexual partner? _____

Do you wish to be checked for sexually transmitted diseases? _____

Do you feel safe at home? _____

Do you smoke? If so, how much? _____

Do you drink alcohol? If so, how much? _____

Have you ever felt the need to cut down? _____

Have you changed your occupation? _____

What kind of exercise are you doing? _____

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING:

Unexplained weight gain or loss ...	yes	no	Abdominal pain	yes	no
Bleeding or bruising tendency	yes	no	Sexual difficulty	yes	no
Hay fever	yes	no	Breast lump	yes	no
High blood pressure	yes	no	Frequent or recurring headaches	yes	no
Asthma or wheezing	yes	no	Depression/Anxiety/Panic	yes	no

Other Concerns: _____

Physician's Initials: _____

Date: _____