DENISE W.L. HEW, M.D., LLC

HEALTH QUESTIONNAIRE — PLEASE ANSWER ALL QUESTIONS. YOUR MEDICAL RECORD IS KEPT ABSOLUTELY CONFIDENTIAL.

PATIENT INFORMATION (please print clearly)

Name _____ Today's date _____

Age _____ Birthdate _____ SSN _____

Race _____ Education _____ Occupation _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated Spouse/partner _____

Reason for appointment _____ Referred by _____

FAMILY HISTORY (please check all that apply and fill in the blank spaces)

HAVE YOUR GRANDPARENTS, PARENTS, BROTHERS, SISTERS, UNCLES, AUNTS, OR CHILDREN EVER HAD OR BEEN TREATED FOR ANY OF THE FOLLOWING (IF YES, PLEASE INDICATE WHO):

- ☐ Cancer _____
  - ☐ Breast _____
  - ☐ Ovary _____
  - ☐ Cervix _____
  - ☐ Uterus _____
  - ☐ Bowel _____
  - ☐ Other _____
- ☐ Heart disease _____
- ☐ High blood pressure _____
- ☐ Lung disorder _____
- ☐ Hepatitis or liver disease _____
- ☐ Kidney or bladder disease _____
- ☐ Diabetes _____
- ☐ Anemia or blood disease _____
- ☐ Muscular disorder _____
- ☐ Nerve disease _____
- ☐ Retardation _____
- ☐ Birth defects _____
- ☐ Epilepsy/seizures _____
- ☐ Osteoporosis _____

PAST MEDICAL HISTORY (please check all that apply and fill in the blank spaces)

HAVE YOU EVER HAD OR BEEN TREATED FOR ANY OF THE FOLLOWING:

- ☐ Thyroid disease
- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Mitral valve prolapse
- ☐ Heart murmur
- ☐ Rheumatic fever
- ☐ Asthma
- ☐ Lung disorder
- ☐ Breast problems
- ☐ Hepatitis or liver disease
- ☐ Kidney or bladder disease
- ☐ Diabetes
- ☐ Anemia or blood disease
- ☐ Blood transfusion
- ☐ Blood clots or phlebitis
- ☐ Cancer (type _____)
- ☐ Muscular disease
- ☐ Headaches
- ☐ Nerve disease
- ☐ Mental disease
- ☐ Epilepsy/seizures
- ☐ Glaucoma
- ☐ Osteoporosis
- ☐ Chicken pox
- ☐ Rubella
- ☐ Other

ALLERGIES TO MEDICINE: _____

CURRENT MEDICATIONS/VITAMINS: _____

_____

DO YOU SMOKE? ☐ YES ☐ NO DRINK ALCOHOL? ☐ YES ☐ NO USE DRUGS? ☐ YES ☐ NO

AMOUNT? _____ AMOUNT? _____ TYPE? _____

PAST SURGICAL HISTORY / HOSPITALIZATIONS (please fill in the blank spaces)

MONTH/YEAR	ILLNESS OR OPERATION	COMPLICATIONS

GYNECOLOGIC - MENSTRUAL HISTORY (please check all that apply and fill in the blank spaces)

First day of last menstrual period (LMP): _____
Age period began? _____
Usually periods are: ☐ Regular ☐ Somewhat irregular ☐ Very irregular
The interval from the start of one period to the start of another period is usually: _____ days
Menstrual flow usually lasts _____ days
Are they painful? ☐ Very ☐ Slightly/a little ☐ Not painful
Ever have any bleeding or spotting between periods? ☐ Yes ☐ No

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Are you sexually active? ☐ Yes ☐ No
Do you have any new or multiple sexual partners? ☐ Yes ☐ No
Do you have bleeding after intercourse? ☐ Yes ☐ No
Do you have any pain with intercourse? ☐ Yes ☐ No

Have you ever had (check any that apply):
☐ Herpes ☐ Condyloma (warts) ☐ Chlamydia ☐ Gonorrhea ☐ Syphilis ☐ Trichomonas

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Are you currently using any birth control? ☐ Yes ☐ No What method/brand? _____
What other methods have you used in the past? (check all that apply)
☐ Condoms ☐ Pills ☐ Ring ☐ Patch ☐ Depo ☐ IUD ☐ Implanon ☐ Tubes tied ☐ Vasectomy

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Date of last Pap smear: _____ Where was it done? _____
Was it normal? ☐ Yes ☐ No
Have you ever had an abnormal Pap smear? ☐ Yes ☐ No

Date of last Mammogram: _____ Where was it done? _____
Date of last Bone density test: _____ Where was it done? _____

OBSTETRICAL HISTORY (please fill in the blank spaces)

Please list the number of:
Times pregnant ____ Premature births ____ Miscarriages ____ Abortions ____ Living children ____

Please provide details on your previous pregnancies:

No.	DATE OF BIRTH	MONTHS PREGNANT	BIRTHWEIGHT	BABY'S SEX	TYPE OF DELIVERY	HRS IN LABOR	COMPLICATIONS
1.							
2.							
3.							
4.							
5.							

Please provide details on your previous miscarriages or abortions:

No.	MONTH & YEAR	HOW FAR ALONG IN PREGNANCY (MONTHS)	CAUSE (IF KNOWN)	D&C DONE?	COMPLICATIONS
1.					
2.					
3.					
4.					
5.					

I hereby certify that the information provided forthwith is accurate to the best of my knowledge.

Signature of patient _____ Date _____
(or parent or guardian if patient is a minor)

Reviewed by _____