GWINNETT ROCKDALE NEWTON
COUNTY HEALTH DEPARTMENTS

Confidential Medical Questionnaire

Date Patient Name Date of Birth Age

Sex: Male Female Transgender How do you like to be identified

How did you hear about us?

Are your immunizations up to date? Are you allergic to latex

Please list any allergies and your reaction

Please list any medications your are currently taking

Have you traveled outside the United States within the last 30 days? Yes No

If yes: Where?

Dates?

FAMILY HISTORY

Any family members (blood relative) have/had the following:

Cancer Type Relationship

Bleeding Disorder Relationship

Blood Clot Disorder Relationship

History of DVT/PE (Blood clots in legs and/or lungs) Relationship

Cardiovascular (Heart Attack, Stroke, High Blood Pressure) Relationship

Heart Disease (Valve Disease, Cholesterol, Heart Murmur) Relationship

Genetic Disorders Relationship

Diabetes Relationship

Other

Social History

Married Never Married Divorced Separated Widowed Partnered

What is your current or past occupation?

Tobacco (specify type) How much How often

Drug (specify type) How much How often

Alcohol (specify type) How much How often

Have you ever been a victim of violence and/or sexual abuse?

Symptoms

Do you have any of the following symptoms (Please circle):

Constitutional

Fever
Fatigue
Significant weight loss/gain
Blurred vision
Change in vision
Loss of vision
Runny nose
Cough
Dry throat
Sinus Congestion

Cardiovascular

Chest pain
Palpitations
Shortness of breath (SOB)
SOB lying down
Swelling in legs

Respiratory

Trouble breathing
Wheezing
Chronic cough

Breasts

Lumps
Pain
Redness
Dimples in skin
Change in size

Skin/Lymph

Rash
Lesions
Nail problems
Lumps

Gastrointestinal

Heartburn
Indigestion
Difficulty swallowing
Nausea
Vomiting
Abdominal pain
Diarrhea/Constipation

Genitourinary

Blood in urine
Abnormal vaginal bleeding
Flank pain
Rash
Lesions
Vaginal discharge
Vaginal odor
Vaginal itching
Change in menstrual cycle
Sexual problems
Pain/Bleeding with sex
Trouble urinating

Musculoskeletal

Muscle pain
Joint pain
Bone pain
Muscle weakness
Leg pain

Neurological

Headaches
Migraines
Migraines with aura
Migraines without aura
Seizures

Psychiatric

Depression
Anxiety

Past Medical History

Are you currently under the care of another medical provider? If yes, who:

Do you have or have you ever had problems with the following?

Cardiovascular
High Blood Pressure
Stroke
Heart Murmur
Increased Cholesterol
Other

Breast
Previous Biopsy
Last Mammogram
Abnormal Mammorgram

Cancer
What type
When
Treatment Given

Genetic Disorders
BRCA Gene
Sickle Cell
G6PD
Other

GI Problems
Crohn's Disease
Gallbladder
Irritable Bowel
Gastritis
Hepatitis
Other

GU Problems
Fibroids
Ovarian Cysts
Endometriosis
Ectopic Pregnancy
PCOS
Frequent UTIs
Other

Metabolic
Diabetes (specify 1 or 2)
Gestational Diabetes
Thyroid Disease
Other

Hematologic
Anemia
Blood Clots (legs or lung)
Bleeding/Blood Clot Disorder
Other

Neurologic
Seizures
Headaches
Migraines with Aura
Migraines without Aura
Other

Respiratory
Asthma
COPD
Other

Psychological
Depression
Anxiety
Bipolar
Other

STD
Type of STD
Last Treated

Autoimmune Disease (Lupus)
Blood Transfusion

Please list any surgical history, including type, date and reason:

Sexual History

Are you currently sexually active? Date of last intercourse: Is your partner: Male Female Both

Type of sexual activity: Genital Oral Both Current number of partners: Number of partners in the last 12 months:

Partner History Does your partner have sex with: Male Female Both Does your partner have a history of IV drug use:

How many other sexual partners Condom Use: Never Sometimes Always

Women's Health History

Age of first period First day of your last menstrual cycle How often do you have your period

How long do you bleed Are your periods: heavy medium light clots

Do you have painful period (cramps)? If yes are the cramps: severe mild

When was your last pap smear?

Have you ever been tested for HPV? Have you had a biopsy or colposcopy? Did you receive treatment?

Have you received the HPV vaccine? If so when Did you receive all 3 parts of the vaccine

Obstetrical History

Have you ever been pregnant: Age of your first pregnancy:

Please list the number of each type of pregnancy: Full-Term Premature Miscarriages Terminations Ectopic

How many living children do you have? Date of your last pregnancy: Do you want future pregnancies?

Are you currently breastfeeding?

What is your plan for pregnancy?

Are you doing anything now to prepare for pregnancy?

Contraceptive History

Current Method of Birth Control: How long have you used this method:

Have you had problems with any previously used birth control: If yes, please describe:

Does your current method of birth control match your desire for pregnancy:

What kind of birth control would you like today:

Patient Name (Please Print)

Patient Signature

Date