Women's Health Center
Patient Questionnaire

KAISER PERMANENTE®

Patient Name: _____

Have you had any of the following in the past 30 days:

General
- ☐ Stress
- ☐ Fatigue (feeling tired or weak)
- ☐ Weight gain
- ☐ Unexplained weight loss
- ☐ Safety concerns

Breast
- ☐ Lumps
- ☐ Pain
- ☐ Nipple discharge

Skin/Hair
- ☐ Lumps
- ☐ Skin changes
- ☐ Hair changes

Respiratory
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ New cough

Heart/Circulation
- ☐ Irregular heartbeat
- ☐ Chest pain
- ☐ Edema/swelling
- ☐ Calf pain

Gastrointestinal
- ☐ Abdominal pain or bloating
- ☐ Changes in bowel movements
- ☐ Heartburn
- ☐ Nausea or vomiting

Genitourinary
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Pain with urination
- ☐ Incontinence (leaking urine)
  - ☐ with urge to urinate
  - ☐ with cough, sneeze, or laugh

If yes, is this bothering you? Y / N
- ☐ Abnormal vaginal discharge or bleeding
- ☐ Painful intercourse
- ☐ Change in libido

Musculoskeletal
- ☐ Arthritis
- ☐ Back pain
- ☐ Joint pain or swelling
- ☐ Bone fractures
- ☐ Weakness

Neurological
- ☐ Confusion
- ☐ Headaches
- ☐ Changes in memory
- ☐ Seizures
- ☐ Numbness or tingling in hands or feet

Psychiatric
- ☐ Depression
- ☐ Anxiety

Hematology
- ☐ Swollen lymph nodes
- ☐ Easy bruising or bleeding

Endocrine
- ☐ Abnormal blood sugars
- ☐ Thyroid problems

Please list any other symptoms you're having that are not listed above:

_____

_____

DO NOT SCAN THIS QUESTIONNAIRE

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GYN History
Age at first period:
Period comes every _____ days
Painful periods? ☐ Yes ☐ No Heavy periods? ☐ Yes ☐ No
Do you have a history of the following:
Pelvic or sexually transmitted infections: ☐ Yes ☐ No
HIV: ☐ Yes ☐ No
Abnormal paps: ☐ Yes ☐ No
Cervical procedures: ☐ Yes ☐ No
Hot flashes or night sweats: ☐ Yes ☐ No
Menopausal symptoms: ☐ Yes ☐ No
Are you currently breastfeeding? ☐ Yes ☐ No
Age at last period: _____ Date of last period: _____
Current Contraception:

Sexual History
Have you been sexually active in the last year? ☐ Yes ☐ No
How many partners in the last year? _____
Is your partner: ☐ Male ☐ Female ☐ Both
How long have you been with your current partner? _____
Have you been sexually or physically abused? ☐ Yes ☐ No
Would you like to talk with us about this during today's visit? ☐ Yes ☐ No

Social History
Smoking ☐ Yes ☐ No ☐ Quit
Alcohol ☐ Yes ☐ No ☐ Quit If yes, how many drinks per week _____
Other Drugs ☐ Yes ☐ No

OB History
Have you ever been pregnant: ☐ Yes ☐ No
If so, please indicate all that apply:
Total number of pregnancies:
☐ Vaginal births: (total number)
☐ Cesarean sections: (total number)
☐ Miscarriages: (total number)
☐ Tubal pregnancies: (total number)
☐ Pregnancy terminations (total number)
☐ Still births: (total number)
☐ Number of living children: (total number)

Family History
☐ Breast Cancer Who: _____ Age ____
☐ Ovarian Cancer Who: _____ Age ____
☐ Uterine Cancer Who: _____ Age ____
☐ Other Cancer Who: _____ Age ____
☐ Blood clots or stroke Who: _____ Age ____
☐ Heart Disease Who: _____ Age ____
☐ Osteoporosis Who: _____ Age ____
☐ Other Who: _____ Age ____

Surgeries: Please list all surgeries (e.g. tonsillectomy, tubal ligation) with the approximate year you had each one:

_____

_____

Past Medical History: Please check all that apply.

☐ Blood clots in legs, lungs	☐ High blood pressure	☐ Seizures
☐ Diabetes in pregnancy	☐ Uterine fibroid	☐ Stroke
☐ Diabetes	☐ High cholesterol	☐ Ovarian tumor
☐ Thyroid disorder	☐ Kidney infections	☐ Endometriosis
☐ Heart problems	☐ Liver or gall bladder problems	

Please list any other medical conditions you've had that are not listed above.

_____

_____