PHYSICAL QUESTIONNAIRE FEMALE

Patient Name:	DOB:	Date:

Do you exercise ☐Yes ☐ No **How many times a week** **Do you take vitamins** ☐ Yes ☐No
Have you had a colonoscopy ☐ Yes ☐ No **Date:** **Where:**
Are you eating : ☐well balanced meals ☐low fat food choices ☐low sodium foods ☐unhealthy meals ☐frequent junk food
How many hours of sleep do you get each night? **Has your recent health been** ☐ Good ☐ Fair ☐ Poor
Date of your last pap smear: **Where:** **Results** ☐Positive ☐Negative
Are you sexually active? **How many pregnancies have you had?**
When was your last menstrual cycle ☐absent ☐regular ☐irregular ☐heavy ☐painful
Do you/ or have you ever smoked or used tobacco ☐ Yes ☐ No **How many packs/cans a day** **How long since you quit?**
Do you use contraceptives ☐ Yes ☐ No **Have you ever used contraceptives** ☐Yes ☐No **What type** _____ **Have you had your tubes tied or a hysterectomy**_____
Do you preform monthly breast exams ☐ Yes ☐ No
Have you had a mammogram ☐ Yes ☐ No **Date of last Mammogram:**
Where was your last mammogram done?
Date of our last bone density test: **Where:**
Are you currently ☐ Pre-menopausal ☐Peri-menopausal ☐Post-menopausal
Are you experiencing any of these menopausal symptoms
☐Mood Swings ☐Night Sweats ☐Hot Flashes ☐ Irregular menstrual cycle ☐Vaginal Dryness ☐Fatigue ☐Irritability ☐Decreased Libido
Surgeries/ Procedures since your last visit to our office?
Other concerns?