PHYSICAL QUESTIONNAIRE FEMALE

Patient Name: **DOB:** **Date**:

Do you exercise ☐Yes ☐ No **How many times a week** **Do you take vitamins** ☐ Yes ☐No

What type of meals do you eat: ☐well-balanced ☐low fat ☐low sodium ☐unhealthy ☐frequent junk food

How many hours of sleep do you get each night? **Has your recent health been** ☐ Good ☐ Fair ☐ Poor

Depression: 1. Little to no pleasure in doing things:

☐ **0 =** Not at all ☐ **1 =** Several days ☐ **2 =** More than half the days ☐ **3 =** Nearly everyday

Depression: 2. Feeling down, depressed, or hopeless:

☐ **0 =** Not at all ☐ **1 =** Several days ☐ **2 =** More than half the days ☐ **3 =** Nearly everyday

Alcohol: How often do you have a drink containing alcohol?

☐ Never ☐ Monthly or less ☐ 2-4 times a month ☐ 2-3 times a week ☐ 4 or more time a week

How many standard drinks containing alcohol do you have on a typical day?

☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-9 ☐ 10 or more

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 per 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 perform monthly breast exams ☐ Yes ☐ No

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 Sex Drive

Surgeries/ Procedures since your last visit to our office?

Other concerns?

OFFICE STAFF ONLY

Colonoscopy ☐ Yes ☐ No **Date:** **Where:**

Date of last pap smear: **Where:** **Results** ☐Positive ☐Negative

Date of last bone density test: **Where:**

Mammogram ☐ Yes ☐ No **Date of last Mammogram:**

Where: