

A FEE OF \$25.00 WILL BE CHARGED IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT AND DO NOT CONTACT OUR OFFICE PRIOR TO 3 HOURS BEFORE YOUR APPOINTMENT.

DR. BRYCE KELPIN - MEDICAL HISTORY SUMMARY QUESTIONNAIRE - FEMALES

PLEASE COMPLETE THE FOLLOWING QUESTIONNAIRE PRIOR TO COMING IN FOR YOUR COMPLETE PHYSICAL EXAMINATION. THIS WILL ASSIST IN FORMULATING A COMPLETE SUMMARY OF YOUR CURRENT AND PAST MEDICAL HISTORY. THIS INFORMATION WILL HELP US TO MAKE THE BEST MEDICAL DECISIONS POSSIBLE IN DETERMINING YOUR HEALTH CARE NEEDS. PLEASE MAKE SURE TO COMPLETE ALL THREE PAGES OF THE QUESTIONNAIRE. THANK YOU.

WHAT IS YOUR CURRENT OCCUPATION? _____

WHAT IS YOUR CURRENT MARITAL STATUS? SINGLE MARRIED OTHER _____

PLEASE LIST THE NAME, SEX AND AGE OF ALL YOUR CHILDREN:

<u>NAME</u>	<u>SEX (M/F)</u>	<u>AGE</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

PLEASE LIST ALL ALLERGIES TO MEDICATIONS _____

PLEASE LIST ALL YOUR CURRENT MEDICATIONS AND DOSAGES, INCLUDING BOTH PRESCRIPTION AND OVER-THE-COUNTER MEDICATIONS:

- | | |
|----------|-----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |
| 7. _____ | 8. _____ |
| 9. _____ | 10. _____ |

DO YOU SMOKE?	YES / NO	HOW MUCH? _____ <u>PACK (s) per day</u>
HAVE YOU SMOKED IN THE PAST?	YES / NO	HOW MUCH? _____ <u>PACK (s) per day</u>
		FOR HOW LONG? _____ <u>QUIT WHEN?</u>
DO YOU DRINK ALCOHOL	YES / NO	HOW MUCH? _____ <u>DAILY</u>
IS YOUR ALCOHOL USE EXCESSIVE?	YES / NO	HAVE YOU SUFFERED FROM ALCOHOLISM? YES / NO

HOW MANY CUPS OF COFFEE DO YOU DRINK DAILY? 0 1 2 3 4 5 6 7 8 9 10 MORE

HOW MANY CUPS OF TEA DO YOU DRINK DAILY? 0 1 2 3 4 5 6 7 8 9 10 MORE

DO YOU EXERCISE REGULARLY? YES / NO HOW MANY TIMES PER WEEK? 0 1 2 3 4 5 6 7

WHAT TYPE OF EXERCISE DO YOU DO? WALK / RUN / SWIM / BICYCLE
OTHER _____

HOW MANY YEARS AGO WAS YOUR LAST TETANUS SHOT? NEVER 1 2 3 4 5 6 7 8 9 10 MORE

TO THE BEST OF YOUR RECOLLECTION, PLEASE LIST ALL OF YOUR PREVIOUS SURGERIES AND THE DATES ON WHICH THEY OCCURRED:

<u>SURGERY</u>	<u>DATE</u>	<u>SURGERY</u>	<u>DATE</u>
1. _____		6. _____	
2. _____		7. _____	
3. _____		8. _____	
4. _____		9. _____	
5. _____		10. _____	

TO THE BEST OF YOUR RECOLLECTION, PLEASE LIST ANY OTHER SIGNIFICANT NON-SURGICAL HEALTH PROBLEMS WHICH YOU HAVE HAD AND THE DATES ON WHICH THEY OCCURRED:

<u>MEDICAL CONDITION</u>	<u>DATE</u>	<u>MEDICAL CONDITION</u>	<u>DATE</u>
1. _____		6. _____	
2. _____		7. _____	
3. _____		8. _____	
4. _____		9. _____	
5. _____		10. _____	

PLEASE LIST ANY PREGNANCIES (LIST THE DATE AND CHECK THE TYPE OF PREGNANCY)

<u>DATE</u>	<u>VAGINAL</u>	<u>CAESARIAN</u>	<u>ABORTION</u>	<u>MISCARRIAGE</u>
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____

HAVE YOU HAD A HYSTERECTOMY?
IF YES, WERE YOU OVARIES REMOVED?

YES / NO
YES / NO

HAVE YOU GONE THROUGH THE MENOPAUSE?
IF YES, ARE YOU ON HORMONE REPLACEMENT THERAPY?

YES / NO
YES / NO

~~IF YOU ARE MENOPAUSAL AND ARE NOT ON HORMONE REPLACEMENT THERAPY WOULD YOU LIKE TO DISCUSS ITS USE?~~

~~YES / NO~~

WHEN WAS YOUR LAST MENSTRUAL PERIOD?
ARE YOUR PERIODS USUALLY REGULAR OR IRREGULAR?

WHEN WAS YOUR LAST PAP SMEAR?
HAVE YOU EVER HAD AN ABNORMAL PAP SMEAR?

YES / NO WHEN? _____

DO YOU DO YOUR OWN BREAST SELF EXAMINATIONS EACH MONTH?
WHEN WAS YOUR LAST MAMMOGRAM?

YES / NO

HAVE YOU EVER HAD AN ABNORMAL MAMMOGRAM?

YES / NO WHEN? _____

PLEASE INDICATE ANY SIGNIFICANT FAMILY HEALTH PROBLEMS:

	<u>AGE IF ALIVE</u>	<u>AGE AT DEATH</u>	<u>SIGNIFICANT HEALTH PROBLEMS</u>
MOTHER	_____	_____	_____
FATHER	_____	_____	_____
BROTHER	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
SISTER	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
OTHER	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

SPECIFICALLY, IS THERE ANY HISTORY OF HEART DISEASE, STROKE, OSTEOPOROSIS, BREAST OR BOWEL CANCER (PLEASE NOTE ABOVE)

DO YOU HAVE ANY OTHER HEALTH CONCERNS AT THIS TIME?

1. _____
2. _____
3. _____
4. _____