

ALL WOMEN'S CARE, PLLC
Elizabeth D. LeBrun, M.D., F.A.C.O.G.
Tracie A. Traver, M.D., F.A.C.O.G.
Steven R. Waller-Smith, M.D.

PATIENT QUESTIONNAIRE

NAME _____ AGE _____ TODAY'S DATE _____

Since your last visit to our office, your life may have changed and this may affect your health.
Please help us to provide the best health care for you by completing this short questionnaire.

What brings you to our office today? _____

Since your last visit, have you changed your occupation that would place you at risk for
environmental exposure? _____

Please indicate whether today's visit is a well-woman visit _____

Do you have any problems or concerns that you would like to discuss with us today? If yes,
please list _____

Date of your last period _____ Has there been a change in your periods?
If yes, please explain _____

Has there been any change with your husband, partner, or boyfriend? _____

Do you want any information about birth control? _____

What method of contraception do you use? _____

Do you have any questions about safer sex? _____

Do you smoke cigarettes? _____ If yes, how many per day? _____

Do you use street drugs? _____ If yes, explain _____

Do you drink alcohol? _____ If yes, how often, and how much? _____

Are you exercising? _____

In the last year, have you been seen by any other physician for any illness or problem?
If yes, please specify problem and doctor seen. _____

Are you taking medicines at the present time? If yes, please list name and dosage. _____

Have you ever had a cholesterol test? _____ If yes, what were the results? _____

If you are over 39: Date of your last mammogram? _____

Date of your last stool test _____