***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 healthcare for you by completing this short questionnaire.***

***Current age:*** _____

***Check Yes or No***
***If yes, please specify.***

Have you changed your occupation? ..... Yes ☐ No ☐ _____

Do you have any problems at home? ..... Yes ☐ No ☐ _____

Has there been any change in your relationship with your husband, partner or boyfriend? ..... Yes ☐ No ☐ _____

Has there been a change in your periods? ..... Yes ☐ No ☐ _____

Date of your last period? _____

Do you use a method of contraception? ..... Yes ☐ No ☐ _____

Do you use it regularly? Are you/your partner satisfied with this method? ..... Yes ☐ No ☐

If yes, what type? pills - IUD - diaphragm - natural/rhythm - sponge - spermicide - condoms - vasectomy - tubal ligation Other _____

Do you want any information about birth control? ..... Yes ☐ No ☐ _____

Date of your last Pap test? _____

Date of your last Mammogram _____ _____

Do you have any questions about safer sex? ..... Yes ☐ No ☐ _____

Do you smoke cigarettes? ..... Yes ☐ No ☐ How many per day? _____

Do you use street drugs? ..... Yes ☐ No ☐ How often? How much? _____

Do you drink alcohol? ..... Yes ☐ No ☐ How often? How much? _____

Have you ever felt the need to cut down on your drinking? ..... Yes ☐ No ☐ _____

Are you exercising? ..... Yes ☐ No ☐ How often? What type?

Have you seen any of your other doctors recently? ..... Yes ☐ No ☐ _____

Current Medications:

_____

_____

_____

_____

_____

_____

_____

**Do you have any questions, problems or concerns that your would like to discuss with us today?**

_____

_____

_____

_____

_____

_____

*(see reverse side)*