

**Please submit your questionnaire to the Women's Comprehensive Health Institute by:**

**Fax:** (210) 450-4970 or

**Mail:** UT Medicine  
C/O Myra Joseph, RN  
8300 Floyd Curl Drive  
Mail Code 8332  
San Antonio, TX 78229

**Questions? Contact the Women's Health Nurse at 210.450.6400**



**UT MEDICINE**

HEALTH SCIENCE CENTER SAN ANTONIO

## Questionnaire

Last Name:  First Name:  DOB:

Current Address:

Daytime Phone #:  Evening Phone #:

Current Occupation:

How did you hear about us?

### General Questions:

Do you have a primary care physician? Yes  No

If yes, please provide physician name, address, phone# and fax number#:

Height:  Weight:

Date of your last annual physical examination:

Where was you last mammogram done? Normal/Abnormal

Do you have breast implants? Yes  No

Are you (Mark with an x): Single  Married  Divorced  Widowed

Male Partner  Female Partner

How many sexual partners now?  How many sexual partners in lifetime?  How many children?

Premenopausal  Postmenopausal

Date of your last menstrual period:

Are you pregnant? yes  no

How would you describe your overall health?

# Past Medical History and Immediate Family History

(i.e. parents, grandparents, siblings)

	Self		Family Member		
	Yes	No	Yes	No	
I was adopted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Which: <input type="text"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Which: <input type="text"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Which: <input type="text"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Which: <input type="text"/>
Arthritis (Osteoarthritis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Which: <input type="text"/>
Autoimmune Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Which: <input type="text"/>
Blood Clot (in a vein or in lung)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Which: <input type="text"/>
Breast Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Which: <input type="text"/>
Cancer (Age at Diagnosis; Breast, Colon, Cervical, Skin, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Which: <input type="text"/>
Cirrhosis of Liver	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Which: <input type="text"/>
Clotting Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Which: <input type="text"/>
COPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Which: <input type="text"/>
Congenital Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Which: <input type="text"/>
Coronary Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Which: <input type="text"/>
Crohn's /Ulcerative Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Which: <input type="text"/>
Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Which: <input type="text"/>
Diabetes Type I (Juvenile onset)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Which: <input type="text"/>
Diabetes Type II (Adult onset)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Which: <input type="text"/>
Dementia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Which: <input type="text"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Which: <input type="text"/>
Difficulty Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Which: <input type="text"/>
Diverticulosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Which: <input type="text"/>
Gestational Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Which: <input type="text"/>
Heart Attack (MI)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Which: <input type="text"/>

# Past Medical History and Immediate Family History

(i.e. parents, grandparents, siblings)

	Self		Family Member		
	Yes	No	Yes	No	
Heartburn (Acid Reflux/GERD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Which: <input type="text"/>
Hemochromatosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Which: <input type="text"/>
Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Which: <input type="text"/>
Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Which: <input type="text"/>
Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Which: <input type="text"/>
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Which: <input type="text"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Which: <input type="text"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Which: <input type="text"/>
History of Illegal Drug Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Which: <input type="text"/>
Infertility Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Which: <input type="text"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Which: <input type="text"/>
Irritable Bowel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Which: <input type="text"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Which: <input type="text"/>
Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Which: <input type="text"/>
Mental Retardation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Which: <input type="text"/>
Osteopenia (Thin Bones)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Which: <input type="text"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Which: <input type="text"/>
Peptic Ulcer Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Which: <input type="text"/>
Peripheral Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Which: <input type="text"/>
Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Which: <input type="text"/>
Stroke/TIA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Which: <input type="text"/>
Transfusions (Blood Products)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Which: <input type="text"/>
Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Which: <input type="text"/>

Past Surgical History (please list any surgeries that you had in the past, including dates):

Current Prescribed Medications (list all medications that you are currently taking prescribed by a physician, include dosage and how often taken):

List any of the following that you currently take:

Over-the-counter medications (aspirin, Tylenol, stool softeners, Phazyme, etc.)

Herbal remedies/supplements (Black Cohosh, Hoodia, etc.)

Vitamin/mineral supplements (Os-Cal, Vitamin C with Rose Hips, etc.)

Do you take any herbal supplements as medication (St. John's Wort, Soy, Licorice, etc)? If yes, please list.

Fen-phen or any other diet pills      yes       no       when and how long:  
Hormone replacement therapy      yes       no       when and how long:

Are you allergic to any of the following? (if yes please explain the reaction you had) (List)

Food	yes <input type="checkbox"/>	no <input type="checkbox"/>	<div style="border: 1px solid black; width: 350px; height: 15px;"></div>
Medications	yes <input type="checkbox"/>	no <input type="checkbox"/>	<div style="border: 1px solid black; width: 350px; height: 15px;"></div>
Bee Stings	yes <input type="checkbox"/>	no <input type="checkbox"/>	<div style="border: 1px solid black; width: 350px; height: 15px;"></div>
Shellfish/Iodine	yes <input type="checkbox"/>	no <input type="checkbox"/>	<div style="border: 1px solid black; width: 350px; height: 15px;"></div>

Do you use tobacco products?      never       currently       Date quit?

Second-hand Smoke Exposure?

If currently smoking cigarettes:      packs per day  
If currently smoking cigars:      pieces per week  
If currently using smokeless tobacco:      packs per day  
Do you ever drink alcohol?      yes       no   
Average drinks per day (Mark with an x):      0 <1       1       2       3       4       >4

Preventive care (indicate most recent date and results if known):

Colonoscopy/Colon Polyps/Adenomas	yes <input type="checkbox"/>	no <input type="checkbox"/>	date: <div style="border: 1px solid black; width: 120px; height: 15px;"></div>	normal <input type="checkbox"/>	abnormal <input type="checkbox"/>
Bone density	yes <input type="checkbox"/>	no <input type="checkbox"/>	date: <div style="border: 1px solid black; width: 120px; height: 15px;"></div>	normal <input type="checkbox"/>	abnormal <input type="checkbox"/>
Pap smear	yes <input type="checkbox"/>	no <input type="checkbox"/>	date: <div style="border: 1px solid black; width: 120px; height: 15px;"></div>	normal <input type="checkbox"/>	abnormal <input type="checkbox"/>
Mammogram	yes <input type="checkbox"/>	no <input type="checkbox"/>	date: <div style="border: 1px solid black; width: 120px; height: 15px;"></div>	normal <input type="checkbox"/>	abnormal <input type="checkbox"/>
Cholesterol profile	yes <input type="checkbox"/>	no <input type="checkbox"/>	date: <div style="border: 1px solid black; width: 120px; height: 15px;"></div>	normal <input type="checkbox"/>	abnormal <input type="checkbox"/>
Dermatology Evaluation/Procedure	yes <input type="checkbox"/>	no <input type="checkbox"/>	date: <div style="border: 1px solid black; width: 120px; height: 15px;"></div>	normal <input type="checkbox"/>	abnormal <input type="checkbox"/>

Are you currently suffering from any of the following (please mark with an x)?

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| Palpitations (irregular or rapid heartbeat sensations)              | yes <input type="checkbox"/> | no <input type="checkbox"/> |
| Chest pain  | yes <input type="checkbox"/> | no <input type="checkbox"/> |
| Arm pain  | yes <input type="checkbox"/> | no <input type="checkbox"/> |
| Syncope   | yes <input type="checkbox"/> | no <input type="checkbox"/> |
| Loss of consciousness   | yes <input type="checkbox"/> | no <input type="checkbox"/> |
| Dizzy spells  | yes <input type="checkbox"/> | no <input type="checkbox"/> |
| Fatigue   | yes <input type="checkbox"/> | no <input type="checkbox"/> |
| Profuse diaphoresis (sweating)                                      | yes <input type="checkbox"/> | no <input type="checkbox"/> |
| Leg swelling  | yes <input type="checkbox"/> | no <input type="checkbox"/> |
| Shortness of breath   | yes <input type="checkbox"/> | no <input type="checkbox"/> |
| Dyspnea on exertion (difficulty walking due to shortness of breath) | yes <input type="checkbox"/> | no <input type="checkbox"/> |
| Lower extremity claudication (difficulty walking due to leg cramps) | yes <input type="checkbox"/> | no <input type="checkbox"/> |
| Nausea/Vomiting   | yes <input type="checkbox"/> | no <input type="checkbox"/> |
| Back or neck pain   | yes <input type="checkbox"/> | no <input type="checkbox"/> |
| Shoulder, knee or hip pain  | yes <input type="checkbox"/> | no <input type="checkbox"/> |
| Seasonal allergies  | yes <input type="checkbox"/> | no <input type="checkbox"/> |
| Diarrhea  | yes <input type="checkbox"/> | no <input type="checkbox"/> |
| Constipation  | yes <input type="checkbox"/> | no <input type="checkbox"/> |
| Abdominal pain/Hernia   | yes <input type="checkbox"/> | no <input type="checkbox"/> |
| Heartburn   | yes <input type="checkbox"/> | no <input type="checkbox"/> |
| Rectal bleeding   | yes <input type="checkbox"/> | no <input type="checkbox"/> |
| Gas/bloating  | yes <input type="checkbox"/> | no <input type="checkbox"/> |
| Abnormal or irregular vaginal bleeding                              | yes <input type="checkbox"/> | no <input type="checkbox"/> |
| Urinary or Fecal Incontinence                                       | yes <input type="checkbox"/> | no <input type="checkbox"/> |
| Pelvic organ prolapse symptoms (vaginal bulge or pressure)          | yes <input type="checkbox"/> | no <input type="checkbox"/> |

Immunizations and Travel (indicate date if known):

- |                             |                              |                             |       |                      |
|-----------------------------|------------------------------|-----------------------------|-------|----------------------|
| Flu                         | yes <input type="checkbox"/> | no <input type="checkbox"/> | date: | <input type="text"/> |
| Tetanus/ TDAP               | yes <input type="checkbox"/> | no <input type="checkbox"/> | date: | <input type="text"/> |
| Pneumonia                   | yes <input type="checkbox"/> | no <input type="checkbox"/> | date: | <input type="text"/> |
| Hepatitis A&@B              | yes <input type="checkbox"/> | no <input type="checkbox"/> | date: | <input type="text"/> |
| MMR (measles/mumps/rubella) | yes <input type="checkbox"/> | no <input type="checkbox"/> | date: | <input type="text"/> |
| Shingles or Meningitis      | yes <input type="checkbox"/> | no <input type="checkbox"/> | date: | <input type="text"/> |

If you lived or traveled outside of the US, please list where and date.

------------------

Do you think you could be at increased risk of HIV infection?      yes       no

Through your occupation were you exposed to any of the following?

- |           |                              |                             |       |                      |
|-----------|------------------------------|-----------------------------|-------|----------------------|
| Chemicals | yes <input type="checkbox"/> | no <input type="checkbox"/> | date: | <input type="text"/> |
| Asbestos  | yes <input type="checkbox"/> | no <input type="checkbox"/> | date: | <input type="text"/> |

Physical activity

- Very active (>5 days/week)
- Active (3-5 days/week)
- Somewhat active (1-2 days/week)
- Not exercising at all

Are you safe in your home?      yes       no

Are you interested in receiving an eye exam?      yes       no

Are you interested in dental services at UT Dentistry next to the MARC?      yes       no

Do you have vision or dental insurance?      yes       no

Please provide us with a copy of your insurance card with forms submitted.

---

Cosmetic Procedures - Would you be interested in a consult about any of the following cosmetic procedures\*?

Nonsurgical anti-aging treatments: yes  no   
(i.e. Botox, Restylane, Juvederm, fat grafts or Obagi Rejuvenating skin treatments)

Body contouring: yes  no   
(i.e. removing unwanted fat or excess skin with liposuction or tummy tuck procedures)

Weight reduction surgery? yes  no

Cosmetic procedures to restore or reconstruct your breasts?  
(lift, reduction or augmentation) yes  no

Please list any prior surgery to your breasts (i.e. biopsy, lumpectomy, radiation, mastectomy or augmentation)

*\*Cosmetic services are reasonably priced but may not be covered by insurance*

*Thank you for completing this questionnaire. We will contact you to discuss your personal itinerary for your exams and verify your insurance benefits, as well as any out of pocket charges you would be responsible for prior to your services.*

***Fax your completed questionnaire and Patient Registration forms to:  
210-450-4970***

***Mail to:  
Women's Comprehensive Health Institute  
C/O Myra Joseph, RN  
8300 Floyd Curl Drive, MC8332  
San Antonio, TX 78229***

***Questions: Call 210.450.6400 (Monday - Friday from 8:00am to 5:00pm)***