Women's Health Questionnaire

Please submit your questionnaire to the Women's Comprehensive Health Institute by:
Fax: 210-450-4970 or **Mail:** UT Health Physicians, c/o Women's Comprehensive Health Institute, 8300 Floyd Curl Drive, Mail Code 8332, San Antonio, TX 78229

Questions? Contact the Women's Comprehensive Health Institute at 210-450-6400.

UT Health San Antonio Physicians

Personal Information

Last name _____ First name _____ Date of birth _____

Address _____ City _____ State _____ Zip _____

Daytime phone # _____ Evening phone # _____

Email address _____ SSN # _____

How did you hear about us? _____

Emergency contact name _____ Phone # _____

General Questions

Do you have a primary care physician? ☐ Yes ☐ No If yes, please provide:

Physician name _____ Physician phone _____

Physician address _____ Physician fax _____

Height _____ Weight _____ Date of your last annual physical examination _____

When was your last mammogram? _____ Results ☐ Normal ☐ Abnormal

Where was it performed? _____

Do you have breast implants? ☐ Yes ☐ No Are you pregnant? ☐ Yes ☐ No

Marital status ☐ Single ☐ Married ☐ Divorced ☐ Widowed Do you have children? ☐ Yes How many? _____ ☐ No

Are you sexually active? ☐ Yes ☐ No Number of sexual partners in the last 12 months _____

Date of your last menstrual period _____ ☐ Premenopausal ☐ Postmenopausal

How healthy do you feel on a scale of 1-10 (circle your answer) 1 2 3 4 5 6 7 8 9 10

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UT Health San Antonio Physicians

Past Medical History and Immediate Family History *(i.e. parents, grandparents, siblings)*

Are you adopted? ☐ Yes ☐ No If yes, please answer the following questions as accurately as possible.

CONDITIONS	SELF		FAMILY MEMBER		WHICH FAMILY MEMBER?
	Yes	No	Yes	No	
Anemia	☐	☐	☐	☐	
Anxiety	☐	☐	☐	☐	
Asthma	☐	☐	☐	☐	
Arthritis *(Osteoarthritis)*	☐	☐	☐	☐	
Autoimmune Disorder	☐	☐	☐	☐	
Blood Clot *(In a Vein or in Lung)*	☐	☐	☐	☐	
Cancer *(Include Type and Age Diagnosed)*	☐	☐	☐	☐	
Cirrhosis of the Liver	☐	☐	☐	☐	
Clotting Disorder	☐	☐	☐	☐	
COPD	☐	☐	☐	☐	
Congenital Heart Disease	☐	☐	☐	☐	
Coronary Artery Disease	☐	☐	☐	☐	
Crohn's /Ulcerative Colitis	☐	☐	☐	☐	
Cystic Fibrosis	☐	☐	☐	☐	
Diabetes Type 1 *(Juvenile onset)*	☐	☐	☐	☐	
Diabetes Type 2 *(Adult onset)*	☐	☐	☐	☐	
Dementia	☐	☐	☐	☐	
Depression	☐	☐	☐	☐	
Difficulty Sleeping	☐	☐	☐	☐	
Diverticulosis	☐	☐	☐	☐	
Gestational Diabetes	☐	☐	☐	☐	
Heart Attack *(MI)*	☐	☐	☐	☐	
Heartburn *(Acid Reflux/GERD)*	☐	☐	☐	☐	

CONDITIONS	SELF		FAMILY MEMBER		WHICH FAMILY MEMBER?
	Yes	No	Yes	No	
Hemochromatosis	☐	☐	☐	☐	
Hepatitis A	☐	☐	☐	☐	
Hepatitis B	☐	☐	☐	☐	
Hepatitis C	☐	☐	☐	☐	
HIV/AIDS	☐	☐	☐	☐	
High Blood Pressure	☐	☐	☐	☐	
High Cholesterol	☐	☐	☐	☐	
History of Illegal Drug Use	☐	☐	☐	☐	
Infertility	☐	☐	☐	☐	
Intellectual Disability	☐	☐	☐	☐	
Irregular Heartbeat	☐	☐	☐	☐	
Irritable Bowel Syndrome	☐	☐	☐	☐	
Kidney Disease	☐	☐	☐	☐	
Kidney Stones	☐	☐	☐	☐	
Osteopenia *(Thin Bones)*	☐	☐	☐	☐	
Osteoporosis	☐	☐	☐	☐	
Peptic Ulcer Disease	☐	☐	☐	☐	
Peripheral Vascular Disease	☐	☐	☐	☐	
Stroke/TIA	☐	☐	☐	☐	
Transfusions *(Blood Products)*	☐	☐	☐	☐	
Varicose Veins	☐	☐	☐	☐	

Surgical History *(list past surgeries and include dates)* _____

_____

_____

_____

_____

_____

Current prescribed medications
(List all medications that you are currently taking prescribed by a physician. Include dosage and how often taken)

Vitamins, minerals or herbal supplements
(Such as aspirin, Tylenol, stool softeners, Phazyme, Black Cohosh, Hoodia, Os-Cal, Vitamin C with Rose Hips, St. John's Wort, Soy, Licorice)

Do you or have you taken:

Fen-phen or any other diet pills ☐ Yes ☐ No Name and dates taken _____

Hormone replacement therapy ☐ Yes ☐ No Name and dates taken _____

Are you allergic to any of the following?

Medications ☐ Yes ☐ No Name of medication _____ Reaction _____

Bee Stings ☐ Yes ☐ No Reaction _____

Shellfish/Iodine ☐ Yes ☐ No Reaction _____

Other food ☐ Yes ☐ No Type of food _____ Reaction _____

Do you use tobacco products? ☐ Never ☐ Currently ☐ Second-hand exposure ☐ Previous smoker Date quit _____

If currently smoking cigarettes Packs per day _____

If currently smoking cigars Number per week _____

If currently using smokeless tobacco Packs per day _____

If currently using vape or e-cig products Times per day _____

Do you drink alcohol? ☐ Yes ☐ No

Average drinks per day ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 4 or more

Do you feel safe in your home? ☐ Yes ☐ No

Preventive Care *(indicate most recent date and results if known)*

Colonoscopy/Colon Polyps/Adenomas	☐ Yes	☐ No	Date _____	☐ Normal	☐ Abnormal
Bone density	☐ Yes	☐ No	Date _____	☐ Normal	☐ Abnormal
Pap Smear	☐ Yes	☐ No	Date _____	☐ Normal	☐ Abnormal
Mammogram	☐ Yes	☐ No	Date _____	☐ Normal	☐ Abnormal
Cholesterol profile	☐ Yes	☐ No	Date _____	☐ Normal	☐ Abnormal

Dermatology evaluation

Actinic Keratosis	☐ Yes	☐ No	Date first diagnosed _____
Skin Cancer	☐ Yes	☐ No	Date first diagnosed _____
Melanoma	☐ Yes	☐ No	Date first diagnosed _____

Are you currently suffering from any of the following?

Abdominal Pain/Hernia	☐ Yes	☐ No
Abnormal or Irregular Vaginal Bleeding	☐ Yes	☐ No
Arm Pain	☐ Yes	☐ No
Back or Neck Pain	☐ Yes	☐ No
Black Stools	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No
Constipation	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No
Dizzy Spells	☐ Yes	☐ No
Dysphagia *(Trouble Swallowing)*	☐ Yes	☐ No
Dyspnea on Exertion *(Difficulty Walking Due to Shortness of Breath)*	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No
Gas/Bloating	☐ Yes	☐ No
Heartburn	☐ Yes	☐ No
Leg Swelling	☐ Yes	☐ No
Loss Of Consciousness	☐ Yes	☐ No
Lower Extremity Claudication *(Difficulty Walking Due to Leg Cramps)*	☐ Yes	☐ No
Nausea/Vomiting	☐ Yes	☐ No
Palpitations *(Irregular or Rapid Heartbeat Sensations)*	☐ Yes	☐ No
Pelvic Organ Prolapse Symptoms *(Vaginal Bulge or Pressure)*	☐ Yes	☐ No
Profuse Diaphoresis *(Sweating)*	☐ Yes	☐ No
Rectal Bleeding	☐ Yes	☐ No
Seasonal Allergies	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Shoulder, Knee or Hip Pain	☐ Yes	☐ No
Unexplained Weight Loss	☐ Yes	☐ No
Urinary or Fecal Incontinence	☐ Yes	☐ No

Immunizations and Travel (indicate date if known):

Flu	☐ Yes	☐ No	Hepatitis A and B	☐ Yes	☐ No
Tetanus/ TDAP	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No
MMR (measles/mumps/rubella)	☐ Yes	☐ No	Shingles or Meningitis	☐ Yes	☐ No

If you lived or traveled outside of the US, please list locations and dates _____

_____

Do you think you could be at increased risk of HIV? ☐ Yes ☐ No

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

Chemicals	☐ Yes	☐ No	Type _____	Dates _____
Asbestos	☐ Yes	☐ No	Date _____	

Physical activity

☐ Very active (5 days/week) ☐ Active (3-5 days/week) ☐ Somewhat active (1-2 days/week) ☐ Rarely exercise

Are you interested in dental services at UT Dentistry? ☐ Yes ☐ No
Are you interested in receiving an eye exam? ☐ Yes ☐ No
Do you have vision or dental insurance? ☐ Yes ☐ No

Cosmetic Procedures* *Are you interested in a consult about any of the following cosmetic procedures?*

Nonsurgical anti-aging treatments *(i.e. Botox, Restylane, Juvederm, fat grafts or Obagi Rejuvenating skin treatments)* ☐ Yes ☐ No
Body contouring *(i.e. removing unwanted fat or excess skin with liposuction or tummy tuck procedures)* ☐ Yes ☐ No
Weight reduction surgery? ☐ Yes ☐ No

Other _____

**Cosmetic services are competitively priced but may not be covered by insurance. We will verify your insurance benefits and co pays of your coverage.*

HOW TO SUBMIT

Prior to your appointment, please fax or mail the following documents:

1. Health questionnaire
2. Patient registration form
3. A copy of the front and back of your insurance card

FAX

210-450-4970

MAIL

UT Health Physicians
c/o Women's Comprehensive Health Institute
8300 Floyd Curl Drive, Mail Code 8332
San Antonio, TX 78229