Questionnaire Form

Please submit your questionnaire to the Women's Comprehensive Health Institute by:
Fax: 210-450-4970 or **Mail:** UT Health Physicians, C/O Myra Joseph, RN
8300 Floyd Curl Drive Mail code 8332, San Antonio, TX 78229

Questions? Contact the Men's Health Nurse at 210-450-6400

Personal Information

Last Name ______________ First Name ______________ DOB ______________

Current Address ______________ City ______________ State ________ Zip Code ________

Daytime Phone # ______________ Evening Phone # ______________

Email Address ______________ SSN# ______________

How did you hear about us? ______________

Emergency contact ______________

General Questions

Do you have a primary care physician? ☐ Yes ☐ No If yes please provide physician name and location

(phone/fax number) ______________

____

Height ________ Weight ________ Date of your last annual physical examination ______________

Where was your last mammogram done? ______________ ☐ Normal ☐ Abnormal

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

Are you *(mark with an x)*: ☐ Single ☐ Married Gender of Spouse *(circle one)* M or F ☐ Divorced ☐ Widowed

Do you have children? ☐ Yes ☐ No If yes, how many? ________ How many sexual partners now? ________

☐ Premenopausal ☐ Postmenopausal Date of your last menstrual period ______________

How would you describe your overall health? ______________

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

CONDITIONS	SELF		FAMILY MEMBER		WHICH FAMILY MEMBER?
	Yes	No	Yes	No	
I was adopted	☐	☐	☐	☐	
Anemia	☐	☐	☐	☐	
Anxiety	☐	☐	☐	☐	
Asthma	☐	☐	☐	☐	
Arthritis *(Osteoarthritis)*	☐	☐	☐	☐	
Autoimmune Disorder	☐	☐	☐	☐	
Blood Clot *(in a vein or in lung)*	☐	☐	☐	☐	
Cancer/Type/Age at Diagnosis	☐	☐	☐	☐	
Cirrhosis of Liver	☐	☐	☐	☐	
Clotting Disorder	☐	☐	☐	☐	
COPD	☐	☐	☐	☐	
Congenital Heart Disease	☐	☐	☐	☐	
Coronary Artery Disease	☐	☐	☐	☐	
Crohn's /Ulcerative Colitis	☐	☐	☐	☐	
Cystic Fibrosis	☐	☐	☐	☐	
Diabetes Type 1 *(Juvenile onset)*	☐	☐	☐	☐	
Diabetes Type 11 *(Adult onset)*	☐	☐	☐	☐	
Dementia	☐	☐	☐	☐	
Depression	☐	☐	☐	☐	
Difficulty Sleeping	☐	☐	☐	☐	
Diverticulosis	☐	☐	☐	☐	
Gestational Diabetes	☐	☐	☐	☐	
Heart Attack *(MI)*	☐	☐	☐	☐	
Heartburn *(Acid Reflux/GERD)*	☐	☐	☐	☐	
Hemochromatosis	☐	☐	☐	☐	

CONDITIONS	SELF		FAMILY MEMBER		WHICH FAMILY MEMBER?
	Yes	No	Yes	No	
Hepatitis A	☐	☐	☐	☐	
Hepatitis B	☐	☐	☐	☐	
Hepatitis C	☐	☐	☐	☐	
HIV/AIDS	☐	☐	☐	☐	
High Blood Pressure	☐	☐	☐	☐	
High Cholesterol	☐	☐	☐	☐	
History of Illegal Drug Use	☐	☐	☐	☐	
Infertility Problems	☐	☐	☐	☐	
Irregular Heartbeat	☐	☐	☐	☐	
Irritable Bowel Syndrome	☐	☐	☐	☐	
Kidney Disease	☐	☐	☐	☐	
Kidney Stones	☐	☐	☐	☐	
Mental Retardation	☐	☐	☐	☐	
Osteopenia *(thin bones)*	☐	☐	☐	☐	
Osteoporosis	☐	☐	☐	☐	
Peptic Ulcer Disease	☐	☐	☐	☐	
Peripheral Vascular Disease	☐	☐	☐	☐	
Sexually Transmitted Disease	☐	☐	☐	☐	
Stroke/TIA	☐	☐	☐	☐	
Transfusions *(blood products)*	☐	☐	☐	☐	
Varicose Veins	☐	☐	☐	☐	

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)*

Food	☐ Yes	☐ No	____________________
Medications	☐ Yes	☐ No	____________________
Bee Stings	☐ Yes	☐ No	____________________
Shellfish/Iodine	☐ Yes	☐ No	____________________

Do you use tobacco products ☐ Never ☐ Currently ☐ Second-hand smoking Date quit ____________________

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)* ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 4 or more

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 (*Circle ones that apply)* ____________

Melanoma or Adenomas	☐ Yes	☐ No	Date	☐ Normal	☐ Abnormal

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

Palpitations (irregular or rapid heartbeat sensations)	☐ Yes	☐ No
Chest pain	☐ Yes	☐ No
Arm pain	☐ Yes	☐ No
Syncope	☐ Yes	☐ No
Loss of consciousness	☐ Yes	☐ No
Dizzy spells	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No
Profuse diaphoresis (sweating)	☐ Yes	☐ No
Leg swelling	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No
Dyspnea on exertion (difficulty walking due to shortness of breath)	☐ Yes	☐ No
Lower extremity claudication (difficulty walking due to leg cramps)	☐ Yes	☐ No
Nausea/Vomiting	☐ Yes	☐ No
Back or neck pain	☐ Yes	☐ No
Shoulder, knee or hip pain	☐ Yes	☐ No
Seasonal allergies	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No
Constipation	☐ Yes	☐ No
Abdominal pain/Hernia	☐ Yes	☐ No
Heartburn	☐ Yes	☐ No
Rectal bleeding	☐ Yes	☐ No
Gas/bloating	☐ Yes	☐ No
Gas/bloating	☐ Yes	☐ No
Abnormal or irregular vaginal bleeding	☐ Yes	☐ No
Urinary or Fecal Incontinence	☐ Yes	☐ No
Pelvic Organ Prolapse Symptoms (vaginal bulge or pressure)	☐ 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 where and date. ______________________________

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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 ☐ No Date ______________ Asbestos ☐ Yes ☐ No Date ______________

Physical activity

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

Please list any prior surgery to your prostate (i.e. biopsy, radiation, TURP or Interstim Implant) ______________________________

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

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 or Mail to:
Women's Comprehensive Health Institute
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, Monday - Friday from 8:00 am to 5:00 pm.