

E. DANIEL BIGGERSTAFF, III, M.D.

ADVANCED HEALTHCARE FOR WOMEN

Experience. Expertise. Excellence.

Please complete the following questionnaire and bring it with you to your appointment. We feel this is the best way to consistently obtain a thorough medical history. The information given will be kept in strictest confidence.

Date _____

Your full name _____ Age _____

Name you prefer we use _____

Height _____ ft. _____ in. Current weight _____ lbs. Weight one year ago _____ lbs.

Weight five years ago _____ lbs.

Please indicate the number of:

Pregnancies _____ Full term deliveries _____ Premature deliveries _____ Living children _____

Miscarriages _____ Pregnancy terminations _____ Ectopic pregnancies _____ Multiple births _____

Please indicate the dates (when applicable) of your most recent:

Menstrual period _____ Prior menstrual period _____ Menopause _____

PAP smear _____ Cholesterol test _____ Mammogram _____ Bone density _____

Colonoscopy/sigmoidoscopy _____

Please write the **reason you made the appointment** _____

What is your **main medical problem**, and how long have you had it (if none, please state so)? _____

Please list **allergies to drugs or reactions to medicines or other substances:** _____

Please list **prior surgical operations** with the date and the surgeon if known:

Anesthetic problems or complications: _____

Social, Dietary, and Exercise History:

Do you **smoke** now? _____ In the past? _____ Amount? _____

How long have you smoked (or did you smoke)? _____ How long ago did you quit? _____

Do you drink **alcoholic beverages**? _____ Weekly amount and kind? _____

Do you use **street drugs**? _____ In the past? _____ What kind? _____

Risk factors for AIDS? Skip to Dietary History if never sexually active.

Have you ever had a positive test for AIDS? _____ Has (any of) your sexual partner(s) ever had a positive test for AIDS? _____ Have you ever had sexual relations with a bisexual? _____

Have you or your sexual partner(s):

Had more than one sexual partner in the last five years? _____ Used intravenous street drugs? _____

Received a blood transfusion prior to 1985? _____ Had sexual relations with a prostitute(s)? _____

Been exposed to AIDS through your occupation (i.e. nurse with inadvertent needle stick)? _____

Received medication to treat or prevent AIDS? _____

Other possible sexually transmitted diseases - Have you or your sexual partner(s) ever had or been treated for: Pelvic inflammatory disease? _____ Gonorrhea? _____ Syphilis? _____ Chlamydia? _____

HPV or venereal warts (condyloma)? _____ Herpes? _____

If yes, when was the most recent treatment or outbreak? _____

Dietary History:

How much **cholesterol** is in your diet?

_____ Low (I never or rarely eat red meats, fish packed in oil, foods made with eggs and fat, whole milk and dairy products made from milk, nuts and seeds, oily dressings and spreads -- I do not eat fried foods).

_____ Moderate (I eat moderate amounts of the above but not on a daily basis).

_____ High (I eat much more red meat than chicken and fish, and frequently eat other high cholesterol foods).

How much **fiber** is in your diet?

_____ Low (I never or rarely eat whole grain cereals, whole wheat breads, fresh fruits and vegetables -- I use highly refined grains such as white flour and their products).

_____ Moderate (I eat moderate amounts of the above but not on a daily basis).

_____ High (I conscientiously eat a high fiber diet and/or use a fiber supplement).

How much **sugar** do you eat?

_____ Low (I do not add sugar to coffee or tea, I rarely eat desserts or sweet snacks, I do not consume alcohol on a regular basis, I do not eat highly refined grains such as white flour on a regular basis).

_____ Moderate (I eat moderate amounts of the above but not on a daily basis).

_____ High (I consume the above on a regular basis).

How much **seafood** is in your diet? (seafood contains Omega-3 fatty acids which help reduce cholesterol levels)

_____ Low (I occasionally eat fish and other seafood, but only rarely).

_____ Moderate (I eat at least two portions of seafood per week).

_____ High (I eat more than two portions of seafood per week).

How much **salt** do you eat?

_____ None (I do not eat any salty foods and never add salt either while cooking or at the table).

_____ Minimal (I rarely eat salty foods and add only small amounts while cooking and at the table).

_____ Moderate (I do not watch my salt, but do not salt my food heavily).

_____ Large amounts (I consistently use large amounts of salt).

How much **caffeine** do you ingest?

- None (no coffee, decaf coffee or tea, tea, caffeine-containing soft drinks, or chocolate).
- Low (I only occasionally eat or drink caffeine-containing products -one cup of coffee per day).
- Moderate (I consume two to four cups of coffee or other sources of caffeine per day).
- Large amounts (I consume large amounts of caffeine daily).

What is your daily intake of **milk/calcium**?

- Low (I rarely drink milk or consume dairy products, and do not take calcium supplements).
- Moderate (I consume an equivalent of two glasses of milk per day or its calcium equivalent).
- Large amounts (I consume at least three glasses of milk per day or its equivalent - this will provide the recommended daily amount of 1200 mg calcium).

Are you a **vegetarian**? If yes, what type? _____

Physical Activity

Do you lead a **sedentary or active** life?

- Very sedentary (no exercise, always take the elevator, do not do yard work, always ride in a car and park close to the destination, do not walk or ride a bicycle for fun, do not participate in any sports)
- Sedentary (occasional exercise, usually take the elevator, not much work in the yard, occasionally go for a walk, etc.)
- Active (regular exercise, regular participation in sports, regular work in the yard, regular play with children or grandchildren, frequently walk up steps rather than ride an elevator, etc.)
- Very active (frequent exercise, regular participation in sports, usually walk up steps rather than take the elevator, always active)

How much do you **exercise**, on average, per week (formal exercise, not counting running after the children, etc.)?

- Medically limited - describe limitation(s) _____
- None
- Occasionally (less than regularly)
- Regularly (20-30 minutes, 3-4 times per week)
- Frequently (30-60 minutes, 4-7 times per week)
- Very frequently (daily for 7 or more hours per week)

Environmental Factors:

What is your occupation? _____ Education (last grade completed)? _____

What are your hobbies? _____

Do you have pets? _____

What is your source of **water supply**? Public with fluoride Public without fluoride
 Public (do not know if have fluoride) Private well Other

What do you use for **birth control**? _____

Husband (partner) vasectomy?

Please list all **Current Medications** (with dosage and frequency, if known): _____

Please check **Illnesses or Conditions** you have had:

- | | |
|--|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Headache/migraine |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Sugar diabetes |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Bowel problems |
| <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Hepatitis or liver disease |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Nervous or mental problems |
| <input type="checkbox"/> Blood clot in a vein or lungs | <input type="checkbox"/> Epilepsy/neurological disorder |
| <input type="checkbox"/> Rh sensitized | <input type="checkbox"/> Breast disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Osteoporosis/osteopenia |
| <input type="checkbox"/> Bleeding tendencies | <input type="checkbox"/> Major accidents |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Tuberculosis/positive skin test |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Emphysema |

Please describe or explain any positive responses: _____

Review of Systems -- Please check (X) ONLY if "yes":

Problems Unique to Women:

- Do you currently have any symptoms of **vaginal problems**?
- | | |
|---|--|
| <input type="checkbox"/> vaginal discharge | <input type="checkbox"/> vaginal itching |
| <input type="checkbox"/> unpleasant odor | <input type="checkbox"/> vaginal dryness |
| <input type="checkbox"/> vaginal irritation | <input type="checkbox"/> difficulty lubricating with intercourse |

- Do you have or have you recently had any **abnormal bleeding**? How long? _____
- | | |
|--|--|
| <input type="checkbox"/> bleeding in between periods | <input type="checkbox"/> excessively long periods |
| <input type="checkbox"/> more than one period per month (even a brown, pink, or red discharge) | |
| <input type="checkbox"/> bleeding after menopause or the change (even a brown, pink, or red discharge) | |
| <input type="checkbox"/> bleeding after intercourse | <input type="checkbox"/> vaginal bleeding this pregnancy |
- Do you have a history of **fibroid tumors of the uterus**?

Do you currently have any **pelvic or low abdominal pain**?

- Pain with your menstrual periods mild moderate severe
- Does the pain start before your period at the same time after
- pain when you have intercourse
- at the entrance to the vagina when your partner goes in deep
- when on your feet for long periods of time
- history of **endometriosis** history of **pelvic infection**
- other -- please describe: _____

Have you ever had an **abnormal pap smear**: _____ When? _____ What was the diagnosis and treatment? _____

Did your mother take DES while pregnant with you? _____

Fertility Problems:

Have you been attempting to become pregnant for more than one year without success? _____
How long? _____ What fertility testing have you had and what were the results?

Have you ever had (please check) or been advised to have any **pelvic surgery**?

_____ biopsy of cervix biopsy _____ other biopsy (please describe) _____
_____ colposcopy _____ cryosurgery _____ cone biopsy
_____ hysteroscopy _____ D&C _____ tubal ligation
_____ laparoscopy _____ laser surgery "tubes tied"
_____ removal of one or both tubes/ovaries (please describe) _____

_____ hysterectomy (removal of uterus or womb)
_____ laparoscopic _____ large abdominal incision _____ removal through vagina
_____ bladder repair (anterior repair)
_____ rectal repair (posterior repair)

What was the reason(s) for your surgery (ies)? _____

Do you currently have any symptoms possibly relating to **premenstrual syndrome (PMS)**? Symptoms are on a regular, cyclic basis, either before, during, and/or after menses. How long do they start before your period? _____ days. Please check all that apply.

_____ cyclic (monthly) weight gain _____ bloatedness or swelling
_____ mood swings _____ headaches
_____ vision changes _____ severe breast tenderness
_____ tiredness _____ other (describe) _____

_____ Are those symptoms severe enough for you to desire therapy to reduce or eliminate them?

_____ Do you currently have any problem or question regarding your **sexual function**? If you have a problem, how long has it existed? _____

_____ decreased sex drive (libido) _____ difficulty becoming aroused (difficult lubrication)
_____ difficulty reaching orgasm or climax _____ other (describe) _____

_____ Do you have any questions or problems related to the **menopause or "change"**?

_____ hot flashes _____ hot flashes with sweats → _____ daytime _____ nighttime
_____ mood swings _____ fatigue and tiredness _____ headaches
_____ irregular bleeding _____ vaginal dryness _____ memory problems
_____ dry skin _____ other (describe) _____

_____ Do you currently have any **breast problems** or have you had any surgery?

_____ discharge from your breasts _____ lumps in your breasts _____ breast pain
_____ breast biopsy _____ mastectomy
_____ augmentation _____ reduction

Have you been instructed to perform breast self-examination? _____ Yes _____ No

Do you examine your breasts monthly? _____ Yes _____ No

Have you ever had a **breast mammogram**? _____ Yes _____ No When? _____

Do you understand that very tiny breast cancers may not be felt by your doctor, and that is why repeat examinations are necessary? _____ Yes _____ No

Do you understand that mammograms are very helpful, but that not all breast cancers can be seen on X-Ray? _____ Yes _____ No

_____ Do you or have you had **urinary tract problems**?

_____ bladder infection(s) or cystitis

_____ How many in the last year? _____ Last one when? _____

_____ kidney infection(s)

_____ other urinary tract disease (describe): _____

_____ burning or pain on urination

_____ frequency of urination

_____ need to urinate during the night -- how many times? _____

_____ loss of urine with coughing, sneezing, running, lifting or straining

_____ feeling you cannot make it to the bathroom

_____ is the loss of urine a significant problem?

_____ other urinary tract problems (describe): _____

_____ Do you currently have **gastrointestinal problems**?

_____ constipation _____ diarrhea _____ constipation and diarrhea

_____ rectal pain or pressure _____ rectal itching _____ rectal bleeding or blood in the stool

_____ regular use of laxatives _____ hemorrhoids

_____ difficulty having a bowel movement so that you have to put a finger in the vagina to assist

_____ other (describe): _____

_____ Do you currently have **constitutional symptoms**?

_____ fever or chills

_____ weight gain _____ lbs. in _____ months weight loss _____ lbs. in _____ months

_____ tiredness

_____ difficulty getting to sleep _____ difficulty staying asleep

_____ Do you currently have **skin and hair problems**?

_____ complexion problems _____ dry skin

_____ recent change in size or color of nevus (mole) -- Where? _____

_____ increased hair growth (chin, lip, etc.) _____ Does this run in your family?

_____ hair loss

Do you have ANY OTHER MEDICAL PROBLEMS that are not covered in this questionnaire? If so, please list: _____

Past Pregnancies:

Delivery Date	Weeks Gestation	Length Labor	Vaginal or C-section	Type of Anesthesia	Sex	Birth Weight	Remarks

Family History: (includes father of the baby if pregnant or anticipating pregnancy)

Do any family members have (had) the following (please indicate which relative or relatives):

- _____ endometriosis _____
- _____ breast cancer _____
- _____ ovarian cancer _____
- _____ uterine cancer _____
- _____ colon cancer _____
- _____ high blood pressure _____
- _____ heart disease _____
- _____ stroke _____
- _____ osteoporosis _____
- _____ sugar diabetes _____
- _____ thyroid disease _____
- _____ AIDS _____
- _____ mental retardation _____
- _____ epilepsy _____
- _____ neural tube defect (including spiny bifida) _____
- _____ Down's syndrome _____
- _____ Tay Sach's _____
- _____ Sickle cell _____
- _____ Muscular dystrophy _____
- _____ Huntington's chorea _____
- _____ hemophilia _____
- _____ cystic fibrosis _____
- _____ other birth defects _____
- _____ multiple pregnancy losses _____
- _____ multiple pregnancies (twins, etc.) _____
- _____ Tuberculosis _____

	Living	Age or age at death	Present health or cause of death
Father	_____ Yes _____ No	_____	_____
Mother	_____ Yes _____ No	_____	_____
Brothers' and sisters' other medical problems: _____			

Children's other medical problems: _____

Other relatives' other medical problems: _____

Religious and Ethnic Background: _____

(Certain diseases may run in families of certain religious or ethnic background).

I have noted or listed all medical problems or conditions that I am aware of in the above questionnaire.

I have provided complete information concerning medical problems or conditions of which I am aware.

Signature_____ Date_____

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