KAMRAN KHAZAEI, MD

Patient Name: ________________________________

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PATIENT'S HEALTH QUESTIONNAIRE

Birthdate: ____/_____/____

Please answer all the questions and fill in the blanks when indicated. All answers to the questions will be for chart use office records only and will be considered confidential.

1. Are you in good health? .... ☐ Y ☐ N
2. My last GYN examination was ________________________________.
3. Are you under the care of a Primary Physician? .... ☐ Y ☐ N
   If so, are you being treated for any conditions? ________________________________.
4. The name, address and phone number of my primary physician is:
   ________________________________.
5. Have you had any serious illnesses or operations? .... ☐ Y ☐ N
   If yes, please list ________________________________
   ____
6. Have you been hospitalized within the last five (5) years? .... ☐ Y ☐ N
   ____

   ____
7. Do you drink alcoholic beverages? ☐ NEVER ☐ SOCIALLY ☐ SOMETIMES ☐ ALWAYS
8. Are you a current cigarette smoker? .... ☐ Y ☐ N
9. Do you have, or have you had, any of the following diseases or problems?
   - Breast conditions? .... ☐ Y ☐ N
     If yes, please list________________________________
   - Gynecological problems? .... ☐ Y ☐ N
     If yes, Please list________________________________
   - Abnormal pap smears? .... ☐ Y ☐ N
     If yes, please list________________________________
   - History of STD'S (venereal disease)? .... ☐ Y ☐ N
     If yes, please list________________________________
   - Personal history of cancer? .... ☐ Y ☐ N
     If yes, please list________________________________
   - Family history of cancer? .... ☐ Y ☐ N
     If yes, please list what family member and what type of cancer________________________________
     ____

10. Are you currently using contraceptives? .... ☐ Y ☐ N
    If yes, please check the following : ☐ Oral Contraceptives, ☐ IUD, ☐ Other________________________
11. Are you taking any medications (drugs), prescription, or non-prescription? .... ☐ Y ☐ N
    If so, please list ________________________________

    ____
12. Do you have any disease, condition or problem NOT listed that you think the doctor and office should be aware of or know about? .... ☐ Y N
    If so, please explain: ________________________________

    ____
13. Are you currently pregnant? .... ☐ Y ☐ N
    - Have you had any previous pregnancies? .... ☐ Y ☐ N

    If yes, please check the following:
    - Vaginal Deliveries: ☐ #_______
    - C Section: ☐ #_______
    - Miscarriage: ☐ #_______
    - Terminations: ☐ #_______
14. Do you have any Allergies? .... ☐ Y ☐ N
    If yes, please check the following and explain:

    - ☐ Food:________________________________
    - ☐ Medication: ________________________________
    - ☐ Latex

I, MYSELF, HAVE FILLED OUT THIS HEALTH QUESTIONNAIRE COMPLETELY AND I HAVE NOTIFIED THE OFFICE OF ALL MY MEDICAL PROBLEMS.

Patient's Signature ________________________________ Date: ____/____/_____

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