Patricia Korber, M.D.
Health Questionnaire

Name: _____ Date: _____ / _____ /_____

PCP: _____ Specialists: _____ Referred by:_____

Height: _____ Weight: _____

Social History: (circle)

Marital Status:	Single	Engaged	Married	Divorced	Widowed
Are you living with your spouse?	Yes	No			
Is your sex life satisfactory?	Yes	No			
Do you have more than one sexual partner?	Yes	No			
Do you use tobacco products?	Yes	No	How many packs per day? _____		
Did you ever use tobacco products in the past?	Yes	No	When did you quit? _____		
Consumption of alcoholic beverages:	Yes	No	How many per day? _____		
Consumption of caffeine beverages:	Yes	No	How many per day? _____		
Do you use recreational drugs?	Yes	No	If yes, what kind? _____		
Do you exercise?	Yes	No	If yes, how often? _____		
Are you employed?	Yes	No	What is your job? _____		

History of Past Illnesses: Have you had / have?

Cancer	Yes	No	If yes, what type? _____ Yr _____		
Chickenpox	Yes	No	Venereal Disease	Yes	No
Diabetes	Yes	No	Blood Clots	Yes	No
Stroke	Yes	No	Rheumatic fever or heart disease	Yes	No
			Other (explain) :_____		

Surgical History

Surgery	Year	Doctor

Have you had a breast augmentation / Implants? Yes No Silicone Saline Year _____

Obstetrical History

Total number of pregnancies _____ Number of deliveries (vaginal or C/S) _____

Number of miscarriages _____ Number of elective abortions _____

Family History

Breast Cancer	Yes	No	Which relative (s)_____
Clotting Disorder	Yes	No	Which relative (s)_____
Colon Cancer	Yes	No	Which relative (s)_____
Diabetes	Yes	No	Which relative (s)_____
Gynecologic Cancer	Yes	No	Which relative (s)_____
Heart Disease	Yes	No	Which relative (s)_____
High Cholesterol	Yes	No	Which relative (s)_____
Hypertension	Yes	No	Which relative (s)_____
Osteoporosis	Yes	No	Which relative (s)_____

Is there any other family information we should know:

_____

_____

_____

Allergies: _____ Reaction: _____

_____ Reaction: _____

_____ Reaction: _____

_____ Reaction: _____

_____ Reaction: _____

Current Medications (include any OTC and herbal):

_____ Dose:_____

_____ Dose:_____

_____ Dose:_____

_____ Dose:_____

_____ Dose:_____

_____ Dose:_____

_____ Dose:_____

_____ Dose:_____

_____ Dose:_____

_____ Dose:_____

What is your current method of birth control? _____

Are you happy with your current method of birth control? Yes No

ANSWER THE FOLLOWING QUESTIONS ONLY IF YOU HAVE MEDICARE:

Did you engage in sexual activity before age 16: _____

Have you had multiple sexual partners? (more than 5 in a lifetime)_____

Do you have a history of a sexually transmitted disease? (including human papillomavirus and/or HIV)_____

Have you had fewer than 3 negative Pap tests within the previous 7 years? _____

Thank you for taking the time to answer these Questions. Most health insurance companies now require this information updated yearly.

SIGNATURE_____ DATE_____

MA _____

Patricia Korber, M.D.

REVIEW OF SYSTEMS

Name:_____ Date_____

Date of Birth:_____/_____/_____ Age:_____ Last Pap Smear_____ Last Mammo_____

Last Menstrual Period: _____ /_____ /_____ How many days between periods _____Length _____

Please check if any of the following symptoms apply to you:

General:
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Fever
- ☐ Fatigue

Eyes:
- ☐ Vision Changes

Ears/Nose/Throat:
- ☐ Hearing Problems
- ☐ Sore Throat

Cardiovascular:
- ☐ Chest pain /Pressure
- ☐ Difficult Breathing

Respiratory:
- ☐ Shortness of Breath
- ☐ Chronic Cough

Musculoskeletal:
- ☐ Muscle/Joint/Back Pain

Neurological / Psychiatric
- ☐ Headaches
- ☐ Depression /Crying Spells
- ☐ Anxiety

Have you ever had:
- ☐ Abnormal Pap Smear
- ☐ Abnormal Mammogram
- ☐ STD

Gynecological:
- ☐ Pelvic Pain
- ☐ Pain with Periods
- ☐ Pain with Intercourse
- ☐ Vaginal Discharge /Odor
- ☐ Vaginal Dryness
- ☐ Change or Irregular Periods
- ☐ Heavy Bleeding with Periods
- ☐ Hot Flashes / Night Sweats

Breast:
- ☐ Breast Lump (s)
- ☐ Breast Pain
- ☐ Nipple Discharge

Urinary:
- ☐ Blood in Urine
- ☐ Pain with Urination
- ☐ Urinary Incontinence

Skin:
- ☐ Rash
- ☐ Change in Mole(s)

Endocrine:
- ☐ Thyroid Problems

Gastrointestinal:
- ☐ Blood in Stool
- ☐ Nausea /Vomiting
- ☐ Frequent Diarrhea /Constipation

Summary:

Is there anything else you feel we should know about that we have not covered?

_____

_____

_____

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SIGNATURE_____ DATE_____

MA _____