Brad Drexler, M.D.

431 A March Ave.
Healdsburg, CA 95448
(707) 431-8843

1144 Sonoma Ave. #119
Santa Rosa, CA 95405
(707) 545-0717

Please print Date:_____
There are three pages to this questionnaire.

Name_____ Age_____ Date of Birth _____

Occupation _____

What is the reason for your visit? _____

Pregnancy history: (List all pregnancies)

Year	Birth weight	Weeks pregnant	Outcome (delivery, abortion, miscarriage)	Complications (during & after)

Gynecological & menstrual history:
_____ First day of your most recent period.
_____ Are your periods regular?
_____ Number of days from the first day of one period to the first day of the next.

Check the appropriate box to describe your periods:
Cramps: ___ None ___ Moderate ___ Severe
Length of flow: ___ 1-3 days ___ 3-6 days ___ 7 days or more
Flow: ___ Light ___ Moderate ___ Heavy
Total number of pads/tampons used on heaviest day of menses: ____

Yes	No	
___	___	Are you currently sexually active with a male partner?
___	___	Are you currently sexually active with a female partner?
___	___	Have you ever used an IUD?
		If yes, which type? _____
___	___	Are you currently using a birth control method?
		If yes, which type? _____
___	___	Would you like to have any birth control method prescribed for you?
		If yes, what method would you prefer? _____
___	___	Do you have any bleeding or spotting between periods?
___	___	Are you currently trying to become pregnant?

When was your last PAP smear? _____

What was the result? _____

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Hospitalizations, illness, and surgery other than pregnancy: (include childhood hospitalizations)

Year Name of facility/Location Type of illness/operation

_____

_____

_____

_____

Yes	No	
___	___	If you are past menopause, have you had any bleeding?
___	___	Do you have pain, bleeding, or other difficulty with intercourse? If yes, please circle.
___	___	Have you had any sexually transmitted diseases? If yes, please circle. Gonorrhea, Chlamydia, Herpes, Syphilis, Genital Warts, Trichomonas, other
___	___	Have you had infected tubes or uterus?
___	___	Has your partner(s) had urethritis (burning/discharge from the penis) in the last 6 months?
___	___	Have you had any recurring vaginal infections?
___	___	Do you have any burning or increased frequency in urination?
___	___	Do you lose any urine when you cough or sneeze?
___	___	Have you had recurring bladder infections?
___	___	Have you ever had an abnormal PAP smear?
___	___	Do you have any recent or unusual breast enlargement, tenderness, or discharge?
___	___	Have you ever had a breast lump?

Allergies: (List allergies to medications) _____

Medications: (List all current medications including over the counter medications such as vitamins, aspirin, etc.) _____

_____

Health habits:

Yes	No	
___	___	Do you smoke tobacco? Packs per day _____ Number of years _____
___	___	Do you drink alcohol? How many drinks per week on average? _____
___	___	Do you use any other drugs daily or weekly? If so, which ones _____
___	___	Have you gained or lost 10 pounds in the last year? What is your usual weight? ____
___	___	Is your diet low in high fat foods such as red meat, fried foods, ice cream, whole milk, or butter?
___	___	Has it been more than 10 years since you have had a tetanus booster?
___	___	Do you exercise regularly? If yes, which activities? _____
___	___	Have you ever had a mammogram? If yes, the last year done: _____
___	___	Have you ever had your cholesterol checked? If yes, the last year done: _____ Was it elevated? ____

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Name: _____

Have your parents, children, or other family members ever had:

Yes	No	If yes, who?	Yes	No	If yes, who?
___	___	Diabetes _____	___	___	Heart disease _____
___	___	Breast cancer _____	___	___	Other cancer _____
___	___	Stroke _____			Type: _____
___	___	Mental illness _____	___	___	High blood pressure _____
___	___	Epilepsy _____	___	___	Elevated cholesterol _____
___	___	Tuberculosis _____	___	___	Genetic diseases _____
___	___	Alcoholism _____			Type: _____

Have you ever had:

Yes	No		Yes	No	
___	___	Diabetes	___	___	Asthma
___	___	Thyroid Disease	___	___	Anemia
___	___	Migraine headaches	___	___	Cancer, type: _____
___	___	Hepatitis, jaundice, liver problems	___	___	Chest pain
___	___	Emotional disorder including	___	___	A blood transfusion
		diagnosed depression	___	___	Heart murmur
___	___	Mitral valve prolapse	___	___	Blood in stools
___	___	Unusual lumps/swelling	___	___	Phlebitis (clotted vein or
___	___	Tuberculosis or positive TB skin test			pulmonary embolism)

Any other medical problems:

_____

_____

_____

_____

_____