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SIBLEY PHYSICIAN GROUP HEALTH QUESTIONNAIRE

Your Name: _____ Age: _____ Today's Date: _____

Diseases in the Family (please list relation)

Breast Cancer : _____

Ovarian Cancer: _____

Colon or Prostate Cancer: _____

Personal History:

Previous surgeries (include date): _____

Medical Conditions: _____

List **ALL** medications you are currently taking, including over the counter medications and vitamins.

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Medication Allergies: _____

Reproductive history:

Last menstrual period: _____ Age of first period _____

Number of pregnancies: _____ Age of first pregnancy: _____

Age of menopause: _____ Hormone Replacement Therapy? _____ Number of years: _____

Review of Systems: (circle yes or no)

Shortness of breath..... Yes No

Chest pain or heart problems..... Yes No

High blood pressure Yes No

Retaining fluid or swelling Yes No

Indigestion or constipation..... Yes No

Stomach Ulcer Yes No

Gallbladder or Liver problems Yes No

Kidney or Bladder problems Yes No

Cancer Yes No

Diabetes Yes No

Thyroid problems Yes No

Nervous System Disorder Yes No

Skin conditions Yes No

Psychiatric conditions Yes No