



ANNUAL QUESTIONNAIRE

Please answer all questions, if a question does not apply, place NA on that line.

NAME: _____ DATE: _____

You are being seen today for an **annual visit** which includes a pap smear (if indicated), a breast exam, an iron check (fingerstick) and urinalysis check, **only**.

- WHAT IS THE FIRST DAY OF YOUR LAST PERIOD? _____
- HOW LONG DOES YOUR PERIOD LAST? _____
- IS THE FLOW LIGHT, MEDIUM OR HEAVY? _____
- WHAT METHOD OF BIRTH CONTROL ARE YOU CURRENTLY USING? _____
- ARE YOU POST MENOPAUSAL (circle one)? YES or NO
- WHAT MEDICATIONS INCLUDING OVER THE COUNTER MEDICATIONS AND VITAMINS ARE YOU TAKING?

- PLEASE LIST ANY ALLERGIES OR DRUG SENSITIVITIES AND WHAT REACTION DID YOU HAVE?

- HAVE YOU HAD ANY MAJOR ILLNESSES, HEALTH CHANGES OR SURGERY SINCE YOUR LAST VISIT?

- WHAT IS YOUR CURRENT OCCUPATION? _____
- DO YOU EXERCISE?
 - WHAT TYPE & HOW OFTEN? _____
- DO YOU SMOKE CIGARETTES? YES or NO
 - HOW MANY PER DAY? _____
- DO YOU DRINK ALCOHOLIC BEVERAGES? YES or NO
 - HOW MANY PER WEEK? _____

500 Medical Center Blvd, Suite 250. Lawrenceville, Georgia 30046
1120 Peachtree Industrial Blvd, Suite 209. Suwanee, Georgia 30024
Phone: 770-979-4700 Fax: 770-979-1060
www.womensgroupofgwinnett.com