Dr. M. Bakhet Patient Questionnaire

Last Name _________________ First Name: _____________________DOB _______________________

Home number _________________________________Cell number _____________________________________

Emergency contact name and number: ____

Weight ________________Height:_______________Family Doctor ____________________________________

Do you work? Yes / No what type of job do you do?____

Are you Allergic to any medications?____

Are you allergic to Latex? Yes / No

Do you smoke? Yes / No if Yes how many per day ______Previous smoker Yes / No year quit

Do you drink alcohol? □ none □ socially □ regularly □ excessively

First day of last menstrual period ____

How frequent is your period? □ 21-24days □ 25-28 days □ 28-35 days □ Others please specify_________

How long does your period last? □ 2-5 days □ 6-8 days □ > 9 days

When did you have your last pap smear?____

What is your marital status? □ Single □ Married □ Common law □ Separated □Widow □ Others

Are you sexually active? Yes / No

What do you use for contraception? □ Nothing □ Birth Control Pills □ Condom □ Tubal Ligation
□ Copper T IUD □ Mirena IUD □ Depo- Provera injection
□ Others please specify _______________________________________

How many children do you have?____

Did you have any miscarriage, abortion or ectopic pregnancies? No / Yes
If Yes how many miscarriage abortion ectopic

Have you ever had any medical problems? □ High Blood pressure □ Bronchial Asthma
□ Thyroid disease □ Overactive □ Under-active
□ Diabetes Mellitus □ Others __________________________

Are you taking any medications? No / Yes please list: ____

Have you had any surgeries? □ C. Section □ Hysterectomy □ Gall Bladder
□ Appendectomy □ Tubal ligation □ Others, please specify _________

Family history of □ Diabetes □ Osteoporosis □ Hypertension
□ Blood clot or pulmonary embolism □ Others please specify
□ Cancer □ ovary □ uterus □ cervix □ breast □ colon