Dr. Kimberly Udell
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Phone: 817-468-1506 Fax 817-468-1520

Name: ________________________________ ____________________
(*Last, First, M.I.*) (*Date of Birth*)

Marital Status:
_____Single _____Partnered _____Married _____Separated _____Divorced ____Widowed

Previous or Referring Doctor: **Date of Last Physical Exam**
___________________________________ ________________________

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.
Please Complete entire questionnaire, sign and date the last page.

Date of last pap__________________________	Yes	No
Age at onset of Menstruation _____________________ Date of Last Menstruation?___________		
Was it on time: ___________________________ How many days do your periods last? __________		
Have you taken birth control pills or Depo Provera in the last year? __________________________		
How many days from the first day of your period to the first day of your next period? __________		
Do you have heavy periods, irregularity, spotting, pain or discharge?		
Comments? ____		
Are you pregnant?		
Are you breastfeeding?		
Any discomfort with intercourse?		
Any urinary tract, bladder, or kidney infections within the last year?		
Any problems with control of urination?		
Any hot flashes or sweating at night?		
Do you have any menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?		
Experienced any recent breast tenderness, lumps, or nipple discharge?		

Mental Health	Yes	No	**Social/Lifestyle History**	Yes	No
Is stress a major problem for you			Do you live alone?		
Do you feel depressed?			Do you have frequent falls?		
Do you panic when stressed?			Do you have vision or hearing loss?		
Do you have problems with eating or your appetite?			Do you smoke?		
Do you cry frequently?			Do you use alcohol?		
Have you ever attempted suicide?			Have you used Marijuana, LSD, Speed		
Have you ever seriously thought about hurting yourself?			Heroin, Crystal, Crack and or Cocaine?		
Do you have trouble sleeping?			What is your occupation? __________________		
Have you every been to a counselor?			What is the highest level of education		
Do you have an advanced Directive and or Living Will?			you have completed? ______________________		
			Are you a vegetarian?		

Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a Major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse.
Would you like to speak with your provider about your risk of this illness? Yes or No

CONTINUED ON BACK SIDE

FAMILY HEALTH HISTORY

Have you, or anyone in your family every had any of the following conditions mentioned below? Please indicate which family member in the comment section.

Serious Illness	Patient	Family
DIABETES MELLITUS		
MALIGNANCIES		
HYPERTENSION		
HEART DISEASE		
RHEUMATIC FEVER		######
PULMONARY DISEASE		
G.I. PROBLEMS		######
RENAL DISEASE		
URINARY TRACT PROBLEMS		######
PHLEBITIS/VARICOSITIES		######
NERVOUS/MENTAL DISORDERS		
METABOLIC/ENDOCRINE ISSUES		
ANEMIA/HEMOBLOBINOOPATH Y		
BLOOD DYSRASIA		
INFECTIOUS DISEASE		

OB/GYN	Patient	Family
CONGENITAL ANOMOLIES		
GENETIC DISEASE		
MULTIPLE BIRTHS		
G/U ANOMOLIES		#######
ABNORMAL UTERINE BLEEDS		#######
INFERTILITY		#######
VENEREAL DISEASE		#######
OPERATIONS/ ACCIDENTS		#######
BLOOD TRANSFUSIONS		#######
HOSPITALIZATIONS		#######
ALLERGIES		#######
MEDICATIONS		#######
OTHER		#######
NO KNOWN DISEASES		

Comments:

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____

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain

	Skin		Bladder		Lungs		**Recent Changes in:**
	Head/Neck		Bowels		Chest/Heart		Weight
	Ears		Circulation		Back		Energy Level
	Nose		**Recent Changes In:**		Intestines		Ability to sleep
	Throat		Weight		Other Pain/Discomfort:		

Comments: ____

PREGNANCY HISTORY

(List all previous pregnancies including miscarriages and abortions)

Number of pregnancies__________ Number of Live births__________

Month/Year	**Weeks At Birth**	**Sex**	**Hours in Labor**	**Type Delivery**	**Weight**	**Complications**

Signatures: ______________________________Date:______________________________