Adult Period Health Review – Patient Questionnaire

<Insert Label> Date:

	Yes	No	Explain (if necessary)
Generally well?			
Smoker			_____ packs per day
Alcohol			_____ glasses/day or week
Heart Active Exercise			_____ minutes or hrs/week
Regular Eye Exams			
Regular Dental Exams			
Shortness of Breath			
Chest pain with exertion			
Regular bowel movements			
Black Tarry Stools			
Urine leakage coughing or sneezing			
Headache			
Joint pain or swelling			
Skin problems			
Mood problems			
Changes in family history			

Men Only			
	Yes	**No**	**Explain (if necessary)**
Erection difficulty			
Testicular self exam			

Women Only			
	Yes	**No**	**Explain (if necessary)**
Regular periods			
Menopause			
Contraception			
Self breast exams			