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“Providing high quality healthcare for all stages in a woman’s life”

PATIENT HISTORY QUESTIONNAIRE

Name: _____ **Date:** _____

Birth Date: _____ **Age:** _____

| Please List Any Allergies To Medications: If no allergies indicate so below. | Reaction |
|---|-----------------|
| | |
| | |
| | |
| | |
| | |

| Please List Below Any Medications You Are Taking Currently (If none then denote it by writing the word NONE below) | | | | |
|---|--|--|--|--|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

| Do you have or ever had: | NO | YES | | NO | YES |
|---------------------------------|-----------|------------|--------------------------|-----------|------------|
| Diabetes | | | Blood Transfusion | | |
| High Blood pressure | | | Kidney Stones | | |
| High Cholesterol | | | Bladder Infection | | |
| Asthma | | | Cancer | | |
| Hypothyroid | | | Other- Please List Below | | |
| Hyperthyroid | | | | | |
| Rheumatoid Arthritis | | | | | |
| Heart Murmur | | | | | |

| Please List Below All Surgeries You Have Had And When (If none then denote it by writing the word NONE below) | | |
|--|--|--|
| | | |
| | | |
| | | |
| | | |
| | | |

Do you smoke? NO _____ YES _____ How much? _____
 Do you drink alcohol? NO _____ YES _____ How much? _____
 Do you engage in recreational drugs? NO _____ YES _____ What kind? _____



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PATIENT HISTORY QUESTIONNAIRE (Continued)

Name: _____ **Date:** _____

Are you: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

Have you ever been pregnant? NO _____ YES _____

If yes, please list all your pregnancies with the year, including miscarriages and abortions:

| Year | Type of Delivery C-section, vaginal or abortion | Male/ Female | Weight | Problems (Diabetes, High Blood Pressure, Bedrest, Preterm Labor, Other) |
|------|--|-----------------|--------|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

When was your last menstrual period? _____ How old were you when you got your first: _____

How many days apart are your periods? _____ How many days do your periods last for: _____

| Have you ever had or have? | NO | YES | Have you ever had or have? | NO | YES |
|---------------------------------|----|-----|----------------------------|----|-----|
| Endometriosis | | | Gonorrhea | | |
| Fibroids | | | Chlamydia | | |
| Ovarian Cysts | | | Trichomonas | | |
| Abnormal Pap | | | Herpes | | |
| Colposcopy | | | Mononucleiosis | | |
| LEEP | | | HIV | | |
| Cryosurgery | | | Hepatitis B | | |
| Laser | | | Hepatitis C | | |
| Pelvic Inflammatory Disease-PID | | | Human Papilloma Virus-HPV | | |

| Has anyone in your family had: | No | Yes | Who |
|--------------------------------|----|-----|-----|
| Cancer | | | |
| High Blood Pressure | | | |
| High Cholesterol | | | |
| Diabetes | | | |
| Stroke | | | |
| Heart Attack | | | |
| Heart Disease | | | |

Thank you for completing the above questionnaire.

All of the above information is correct to the best of my knowledge.

Signature _____ Date _____