Reason for today's visit

Chief complaint:

Referring Physician

Marital status: S M SEP D W Race

Needs interpreter: ☐ Yes ☐ No

Occupation

MEDICAL HISTORY (Check appropriate box)

Have you or any members of your family had:	You	Your Family
1. High cholesterol	☐	☐
2. Heart disease	☐	☐
3. Rheumatic fever	☐	
4. High blood pressure	☐	☐
5. Asthma	☐	
6. Tuberculosis	☐	
7. Diabetes	☐	☐
8. Gestational Diabetes	☐	☐
9. Thyroid problems	☐	☐
10. Liver disease	☐	
11. Stomach, bowel or gall bladder problems	☐	
12. Kidney or bladder problems	☐	
13. AIDS (HIV)	☐	☐
14. Hepatitis – type	☐	☐
15. Anemia or blood disorder	☐	☐
16. Blood transfusion	☐	
17. Breast problems	☐	☐
18. Cancer	☐	☐
19. Infertility	☐	
20. Female or sexual problems	☐	
21. Chlamydia	☐	
22. Gonorrhea	☐	
23. Herpes (HSV)	☐	
24. Syphilis	☐	
25. Birth defects or inherited diseases	☐	☐
26. Osteoporosis	☐	☐
27. Mental Health Issues	☐	☐

28. SURGERIES & HOSPITALIZATIONS

List those operations or serious illnesses that have required hospitalization. If more than five, check this box. ☐

DO NOT INCLUDE PREGNANCIES.

Mo/Year	Illness/Operation	Complication Yes	No
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐

29. CURRENT MEDICATIONS

Medication	Dose	How often

Over the Count Medications:

Vitamins/Herbs:

30. ALLERGIES

List All ☐ None

31. PREGNANCY HISTORY (Complete all information)

☐ Check box if more than 5

Pregnancies # of	Premature Births # of	Miscarriages # of	# of Spontaneous Abortions	# of Induced Abortions	# of Living Children

# of Births Month / Year	Sex	Weight at Birth	Weeks Pregnant (term 40 wk)	Hours in Labor	Type of Delivery	Type of Anesthesia	Complications Yes	No
							☐	☐
							☐	☐
							☐	☐
							☐	☐
							☐	☐

32. MENSTRUAL HISTORY

First day of last menstrual period / /

Menarche (age at first period)

# of days between periods

Length of period days

Abnormalities: ☐ Excessive Bleeding ☐ Discharge ☐ Pain ☐ None

33. CONTRACEPTIVE HISTORY

Current type of contraception used:

Other previously used types:

☐ Birth Control Pill ☐ Norplant
☐ Condoms ☐ Spermicide
☐ Diaphragm ☐ Sponge
☐ Depo Provera ☐ Other
☐ IUD

Sterilization: ☐ Male ☐ Female

PROVIDER NOTES

LIFESTYLE

	Yes	No
34. Did your mother take DES or any other hormones when pregnant with you?	☐	☐
35. Have you ever had a Pap Test? If yes, date of last / /	☐	☐
36. If abnormal Pap test, describe treatment:		
37. Are you sexually active?	☐	☐
38. Do you have one partner?	☐	☐
or more than 1 partner?	☐	☐
39. Is intercourse painful for you?	☐	☐
40. Do you do a monthly breast exam?	☐	☐
41. Have you ever had a mammogram? If yes, date of last / /	☐	☐
42. Do you exercise on a regular basis? If yes, Type of exercise; Hours per week	☐	☐
43. Are you Rubella immune?	☐	☐
44. Have you had chicken pox?	☐	☐
45. Have you ever been hit, kicked, pushed or otherwise hurt or mistreated by someone important to you?	☐	☐
46. Is someone important to you yelling at you, threatening you, or otherwise trying to control your life?	☐	☐

REVIEWED FORM
Date / Initials

(PLEASE PRINT)

Patient Name

DOB Soc. Sec. #

Today's Date

Home Phone:

Work Phone: Cell Phone:

HEALTH HISTORY (OVER)

SUBSTANCE USE (Check only those you use)

☐ **Alcohol**	☐ **Tobacco**	☐ **Caffeine**	☐ **Non-Prescribed Drugs**	☐ **Street Drugs**
Type	Type	Type	Type	Type
Amt/Day	Amt/Day	Amt/Day	Amt/Day	Amt/Day

Currently experiencing any of the following:

GENERAL:
- ☐ Excessive fatigue
- ☐ Unexplained weight loss
- ☐ Excessive thirst
- ☐ Risk of AIDS
- ☐ Lumps or swelling, where?

SKIN and HAIR:
- ☐ Recurrent skin rash
- ☐ Sores that do heal
- ☐ Moles that have changed color or size
- ☐ *None of the above*

EYE, EARS, NOSE and THROAT:
- ☐ Loss of hearing
- ☐ Prolonged roaring or ringing in the ears
- ☐ Ear pain or discharge
- ☐ Disturbances in vision
- ☐ Recurrent nose bleeds
- ☐ Chronic nasal obstruction or discharge
- ☐ Persistent dental problems
- ☐ Hoarseness or voice changes
- ☐ *None of the above*

HEART, LUNGS and CIRCULATION:
- ☐ Chronic cough
- ☐ Coughing up blood
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Chest discomfort
- ☐ Chest discomfort with exercise
- ☐ Palpitations or irregular heartbeat
- ☐ Heart murmur
- ☐ *None of the above*

SKELETON and JOINTS:
- ☐ Swollen or painful joints
- ☐ Neck pain
- ☐ Gout
- ☐ Back trouble
- ☐ Difficulty walking
- ☐ *None of the above*

DIGESTIVE SYSTEM:
- ☐ Frequent belching
- ☐ Recurrent abdominal pain
- ☐ Difficulty swallowing
- ☐ Tarry (black) or blood in stool
- ☐ Frequent nausea or vomiting
- ☐ Changes in bowel habits
- ☐ Persistent constipation
- ☐ Frequent diarrhea
- ☐ Hemorrhoids
- ☐ *None of the above*

NERVOUS SYSTEM:
- ☐ Frequent or severe headaches
- ☐ Attacks of staggering or loss of balance
- ☐ Unexplained dizziness
- ☐ Loss of consciousness (blacking out)
- ☐ Weakness of limbs
- ☐ Twitching or tremors (shaking)
- ☐ Persistent or recurrent numbness or tingling in hands / feet
- ☐ Episode of difficulty in talking
- ☐ *None of the above*

PSYCHIATRIC:
- ☐ Anxiety
- ☐ Irritability and mood swings
- ☐ Feeling depressed or “blue”
- ☐ Suicidal thoughts
- ☐ Difficulty memorizing or concentrating
- ☐ Sexual problems or loss of interest
- ☐ Have you ever had psychiatric help
- ☐ *None of the above*

URINARY SYSTEM:
- ☐ Difficult or painful urination
- ☐ Urination more than once a night
- ☐ Poor bladder control
- ☐ Recurrent bladder or kidney infection
- ☐ Blood in urine
- ☐ History of kidney stone
- ☐ Have you ever seen a Urologist
- ☐ *None of the above*

Are there any other problems that are important to you? ☐ No ☐ Yes

Patient Signature: Provider Initials: