



**Date:** \_\_\_\_\_

**Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Reason for Visit:**  Annual Exam  Problem: \_\_\_\_\_

**PAST MEDICAL HISTORY**

	Yes	If yes, please list dates and type of problem:
Alcoholism		
Anemia		
Anxiety		
Arthritis/Joint problems		
Asthma		
Back problems		
Bladder problems		
Blood clots in veins		
Blood transfusions		
Bowel problems		
Cancer		
Chronic lung disease		
Depression		
Diabetes		
Endometriosis		
Fibroids		
Fracture		
Glaucoma		
Mitral valve prolapse		
Heart trouble		
Hepatitis/Liver disease		
High blood pressure		
High cholesterol		
High triglycerides		
Kidney infections/disease		
Migraines		
Need antibiotics for prophylaxis		
Seizure Disorder		
Stroke		
Thyroid Disorder		
Other:		

**SCREENING TESTS:** (please list most recent results and where performed)

Last pap smear (date/results/M.D.) \_\_\_\_\_

Ever abnormal?  Yes  No Details: \_\_\_\_\_

Cholesterol \_\_\_\_\_ Thyroid \_\_\_\_\_

Blood count/ Hematocrit \_\_\_\_\_

Mammogram: \_\_\_\_\_

Bone density: \_\_\_\_\_

Colonoscopy: \_\_\_\_\_

Flu vaccine (year) \_\_\_\_\_ Pneumonia vaccine (year) \_\_\_\_\_ Hepatitis B vaccine \_\_\_\_\_

**PAST SURGICAL HISTORY**

Year	Illness or Operation	Complications?

**MEDICATIONS** (prescription and non-prescription medications, vitamins, birth control, herbs etc)

Name	Dosage (mg)	Frequency	Date Started	Prescribing MD

**ALLERGIES** (drugs, foods, latex)                      **REACTION**


**FAMILY HISTORY** (please fill in the **age of onset** of each condition)

	Mother	Father	Sister	Brother	Mother's mother	Mother's father	Father's mother	Father's father	Aunt
Blood clots in veins									
Bleeding disorder									
Stroke									
Diabetes									
Heart disease									
High blood pressure									
Osteoporosis									
Thyroid disease									
Dementia									
Breast cancer									
Ovarian cancer									
Colon cancer									
Other cancer									
Psychiatric Problems									
Other Diseases									

Age/State of Health

Mother: \_\_\_\_\_ Father: \_\_\_\_\_

Spouse: \_\_\_\_\_ Children: \_\_\_\_\_



**REVIEW OF SYSTEMS:** (please check all that apply to you today)

	Yes		Yes
<b>Constitutional</b>		<b>Gynecological</b>	
Fatigue		Vaginal discharge	
Fever		Irregular bleeding	
Chills		Painful periods	
<b>HENT</b>		Painful intercourse	
Headaches		<b>Integumentary</b>	
Sore throat		Genital sores/bumps	
<b>Breasts</b>		Unexplained lumps	
Breast lumps		Acne	
Nipple discharge		<b>Musculoskeletal</b>	
Breast pain		Back Pain	
<b>Cardiovascular</b>		Joint Pain	
Chest Pain		<b>Endocrine</b>	
Heart Palpitation		Weight loss	
<b>Respiratory</b>		Weight gain	
Wheezing		<b>Psychological</b>	
Cough		Anxiety	
Shortness of breath		Depression	
<b>Gastrointestinal</b>		Difficulty sleeping	
Abdominal pain		Panic attacks	
Nausea		<b>HEME/Lymph</b>	
Vomiting		Easy bruising	
Constipation		Easy Bleeding	
Diarrhea		<b>Allergic/Immunological</b>	
Blood in stool		Hay Fever	
Change in bowel habits		Sinus congestion	
<b>Genitourinary</b>			
Painful urination			
Leaking urine			
Urinary urgency			
Urinary frequency			
Blood in urine			
Nocturia (urinating 2 or more times/night)			