



\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Last Name First Name Initial Age Today's Date  
 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Date of Birth Last Period Last Pap Last Mammogram

**Reason For Today's Appointment:**

REVIEW OF SYSTEMS: Please Check (✓) any boxes that apply to you now or have applied in the past			
	Current	Past	Notes
<b>1. <u>Constitutional</u></b> Weight loss Weight gain Fever Fatigue	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<b>2. <u>Eyes</u></b> Double vision Spots before eyes Vision changes	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<b>3. <u>Ears/Nose/Throat/Mouth</u></b> Ear aches Ringing in ears Sinus problems Sore throat Mouth sores Dental problems	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<b>4. <u>Cardiovascular</u></b> Painful breathing Chest pain Difficult breathing on exertion Swelling of legs Palpitations of heart	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<b>5. <u>Respiratory</u></b> Wheezing Spitting up blood Shortness of breath Chronic cough	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<b>6. <u>Gastrointestinal</u></b> Frequent diarrhea Blood stool Nausea/vomiting Constipation	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<b>7. <u>Genitourinary</u></b> Blood in urine Pain with urination Urgency Frequency of urination Incomplete emptying Stress incontinence Abnormal periods Painful intercourse	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<b>8. <u>Musculoskeletal</u></b> Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>	
<b>9. <u>Skin/Breast</u></b> Pain in breast Discharge Masses Rash ulcers	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	

<b>REVIEW OF SYSTEMS (continued):</b> Please Check (✓) any boxes that apply to you now or have applied in the past			
	<b>Current Past</b>		<b>Notes</b>
<b>10. Neurological</b>			
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	
Numbness	<input type="checkbox"/>	<input type="checkbox"/>	
Trouble walking	<input type="checkbox"/>	<input type="checkbox"/>	
<b>11. Psychiatric</b>			
Depression	<input type="checkbox"/>	<input type="checkbox"/>	
Frequent crying	<input type="checkbox"/>	<input type="checkbox"/>	
<b>12. Endocrine</b>			
Dry skin	<input type="checkbox"/>	<input type="checkbox"/>	
Abnormal thirst	<input type="checkbox"/>	<input type="checkbox"/>	
Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>	
<b>13. Hematologic/lymphatic</b>			
Frequent bruises	<input type="checkbox"/>	<input type="checkbox"/>	
Cuts that do not stop bleeding	<input type="checkbox"/>	<input type="checkbox"/>	
Enlarged lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>	
<b>14. Allergic/Immunologic</b>			
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	
Drug allergies	<input type="checkbox"/>	<input type="checkbox"/>	

<b>Personal Past History:</b> Please Check (✓) any boxes that apply to you now or have applied in the past					
<b>Major Illnesses</b>	<b>Yes</b>	<b>No</b>	<b>Major Illnesses</b>	<b>Yes</b>	<b>No</b>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Depression/anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Infection/stones	<input type="checkbox"/>	<input type="checkbox"/>	Anemia/blood transfusions	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Seizures/convulsions/epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Bowel trouble	<input type="checkbox"/>	<input type="checkbox"/>
Heart Trouble/murmur	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/joint pain	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Fracture	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/yellow jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>

<b>Family History:</b> Please Check (✓) YES if a Family Member has or had one of these illnesses							
<b>Illnesses</b>	<b>Yes</b>	<b>No</b>	<b>Family Member</b>	<b>Illnesses</b>	<b>Yes</b>	<b>No</b>	<b>Family Member</b>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		Drinking Problem	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	<input type="checkbox"/>		Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>		Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>		Ovarian Cancer	<input type="checkbox"/>	<input type="checkbox"/>	

<b>Social History: Personal Habits</b>			
	<b>Yes</b>	<b>No</b>	
Smoking	<input type="checkbox"/>	<input type="checkbox"/>	Packs per day: _____ Years: _____
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	Drinks per day: _____ Drinks per week: _____
Drug Use	<input type="checkbox"/>	<input type="checkbox"/>	
Seat Belt Use	<input type="checkbox"/>	<input type="checkbox"/>	
Regular Exercise	<input type="checkbox"/>	<input type="checkbox"/>	

<b>Personal Profile</b>	
Marital Status:	Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>
Number of Living Children	_____
Number of people in household	_____
School Completed	High School <input type="checkbox"/> College <input type="checkbox"/> Graduate Degree <input type="checkbox"/> Other <input type="checkbox"/>
Current or Most Recent Job	_____

<b>Personal Safety</b>	<b>Yes</b>	<b>No</b>
Has anyone close to you ever threatened to hurt you?	<input type="checkbox"/>	<input type="checkbox"/>
Has anyone ever hit, kicked, choked, or hurt you physically?	<input type="checkbox"/>	<input type="checkbox"/>
Has anyone, including a partner, ever forced you to have sex?	<input type="checkbox"/>	<input type="checkbox"/>
Are you ever afraid of your partner?	<input type="checkbox"/>	<input type="checkbox"/>

Date	Hospitalizations/Surgeries

Medications	list all medications/supplements/vitamins	Reason

**Allergies: (list reaction)**

**Pregnancy History:**

Year Delivery	Vaginal, C/S, Miscarriage, Abort or Ectopic	Gender/Weight	Hospital/Complications

**Gynecological History:**

**Pap smears:** Have you ever had any abnormal pap smears:       Y       N

**Menses:**

Age when menses began \_\_\_\_\_

Periods come every \_\_\_\_\_ days and last for \_\_\_\_\_ days

Blood flow during period is:       light       moderate       heavy

Are your periods painful?       Y       N

**Birth Control:**

Are you having intercourse?       Y       N

Have you ever had any sexually transmitted infections?       Y       N

What birth control are you currently using? \_\_\_\_\_

Do you want to change your birth control method?       Y       N

**Please check any symptom(s) you are currently having:**

- |   |  |
|---|--|
| <input type="checkbox"/> Irregular periods                  | <input type="checkbox"/> hot flashes   |
| <input type="checkbox"/> Pain with your menses              | <input type="checkbox"/> trouble sleeping vaginal dryness                            |
| <input type="checkbox"/> Pain with ovulation                | <input type="checkbox"/> night sweats  |
| <input type="checkbox"/> Dissatisfied with sexual relations | <input type="checkbox"/> feel anxious  |
| <input type="checkbox"/> Pain with intercourse              | <input type="checkbox"/> feel sad/depressed  |
| <input type="checkbox"/> Bleeding between periods           | <input type="checkbox"/> strong urge to urinate                                      |
| <input type="checkbox"/> Bleeding after intercourse         | <input type="checkbox"/> the sight or sound of running water cause you to leak urine |
| <input type="checkbox"/> Bleeding from your rectum          | <input type="checkbox"/> unaware that you are leaking urine                          |
| <input type="checkbox"/> Vaginal discharge                  | <input type="checkbox"/> leak urine when you cough, laugh, or sneeze                 |
| <input type="checkbox"/> Vaginal itching                    | <input type="checkbox"/> wear a pad because of urine leakage                         |
| <input type="checkbox"/> Vaginal burning                    | <input type="checkbox"/> feeling of pressure or bearing down                         |
| <input type="checkbox"/> Breast discharge                   | <input type="checkbox"/> bulging from your vagina                                    |
| <input type="checkbox"/> lump(s) in breast                  |  |
| <input type="checkbox"/> unusual hair growth                |  |

Annual Review of History:

Date reviewed: \_\_\_\_\_ Physician Signature: \_\_\_\_\_

Date reviewed: \_\_\_\_\_ Physician Signature: \_\_\_\_\_

Date reviewed: \_\_\_\_\_ Physician Signature: \_\_\_\_\_