

Name _____ Age _____ Date _____

Medications _____

Allergies _____ Birth control method _____

Hospitalizations or Surgeries:

Date:	Surgery or reason for hospitalization:

<p>Menstrual history First day of last period _____ How many days does your period last? _____ Days from the start of one period until the next _____ Age period began _____ Age period ended _____</p>	<p>Pregnancy history Number of pregnancies _____ Dates of pregnancies _____ Number of miscarriages _____ Number of abortions _____</p>
--	---

Date of: last pap smear _____ last mammogram _____ last bone density test _____

Family history: Please indicate whether immediate relatives (parents, children, grandparents, aunts/uncles) have had any of the following:

Breast cancer _____	High cholesterol _____	Alzheimer's disease _____
Ovarian cancer _____	High blood pressure _____	Depression _____
Cervical cancer _____	Heart attack _____	Anxiety _____
Uterine cancer _____	Aneurysms _____	Thyroid disease _____
Skin cancer _____	Stroke _____	Alcoholism _____
Colon cancer _____	Osteoporosis _____	Diabetes _____
Other cancer _____		

Social History: I live with _____ Marital status _____ Occupation _____

Do you smoke? _____ Packs per day _____ Do you drink? _____ Drinks per week _____ Do you use drugs? _____

Health problems or concerns. Mark "C" for current problems and "X" for past problems.

<p>General</p> <p><input type="checkbox"/> Cancer <input type="checkbox"/> Anemia <input type="checkbox"/> Blood clot in lungs or leg <input type="checkbox"/> Eating disorder <input type="checkbox"/> Unusual fatigue <input type="checkbox"/> Abnormal thirst <input type="checkbox"/> Sleeping problems <input type="checkbox"/> Skin trouble <input type="checkbox"/> Back pain</p> <p>Neurological</p> <p><input type="checkbox"/> Frequent headaches <input type="checkbox"/> Fainting spells <input type="checkbox"/> Seizures <input type="checkbox"/> Dizzy spells <input type="checkbox"/> Depression or anxiety</p> <p>Neck</p> <p><input type="checkbox"/> Goiter <input type="checkbox"/> Lump <input type="checkbox"/> Pain or stiffness</p>	<p>Heart</p> <p><input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart murmur <input type="checkbox"/> Heart attack/problems <input type="checkbox"/> Stroke <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Night sweats <input type="checkbox"/> Chest pain or pressure <input type="checkbox"/> Palpitation or fluttering <input type="checkbox"/> Swollen ankles</p> <p>Lungs</p> <p><input type="checkbox"/> Asthma <input type="checkbox"/> Pneumonia <input type="checkbox"/> Chronic cough</p> <p>Breast</p> <p><input type="checkbox"/> Lump <input type="checkbox"/> Discharge <input type="checkbox"/> Pain</p>	<p>Intestinal</p> <p><input type="checkbox"/> Ulcers <input type="checkbox"/> Bowel problems <input type="checkbox"/> Hepatitis <input type="checkbox"/> Gallbladder problems <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Nausea or vomiting <input type="checkbox"/> Vomiting of blood <input type="checkbox"/> Pain in abdomen <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Blood in stools <input type="checkbox"/> Black, tarry stools</p> <p>Pelvic and genital</p> <p><input type="checkbox"/> Endometriosis <input type="checkbox"/> Fibroids <input type="checkbox"/> Chlamydia or gonorrhea <input type="checkbox"/> Herpes <input type="checkbox"/> Abnormal pap smear <input type="checkbox"/> Pelvic pain <input type="checkbox"/> Irregular periods <input type="checkbox"/> Painful periods <input type="checkbox"/> Hot Flashes <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Vaginal irritation</p>	<p>Urinary</p> <p><input type="checkbox"/> Kidney infections/stones <input type="checkbox"/> Bladder infections <input type="checkbox"/> Frequent urination <input type="checkbox"/> Pain with urination <input type="checkbox"/> Urine leakage <input type="checkbox"/> Blood in urine</p> <p>Endocrine</p> <p><input type="checkbox"/> Thyroid disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Osteoporosis</p> <p>Extremities</p> <p><input type="checkbox"/> Arthritis, joint pain <input type="checkbox"/> Varicose veins <input type="checkbox"/> Broken bones</p> <p>Any other illnesses or symptoms:</p>
--	--	---	--

Do you have any special problems or concerns today that are not listed above? _____

Thank you for taking the time to complete this questionnaire. It will allow us to more completely address your needs and concerns.

