

PERSONAL MEDICAL HISTORY

MAJOR ILLNESSES	YES	Heart Disease	YES	Anxiety	YES
Diabetes		Heart Disease		Anxiety	
High Blood Pressure		High cholesterol		Depression	
GI Reflux disease		Hepatitis		Seizures	
Other GI disease		Liver problem		Asthma	
Fibroids		Kidney infections/stones		Lung disease	
Endometriosis		Arthritis		Tuberculosis	
Osteopenia		Joint Pain		Thyroid disease	
Osteoporosis		Fracture		Clotting disorder	
Cancer (Type)					
Add others/Explain:					

SURGICAL HISTORY

SURGERY	YEAR	SURGERY	YEAR

FAMILY HISTORY

MAJOR ILLNESSES	YES	Heart Disease	YES	Anxiety	YES
Diabetes		Heart Disease		Anxiety	
High Blood Pressure		High cholesterol		Depression	
GI Reflux Disease		Hepatitis		Seizures	
Other GI disease		Liver problem		Asthma	
Fibroids		Kidney infections/stones		Lung disease	
Endometriosis		Arthritis		Tuberculosis	
Osteopenia		Joint pain		Thyroid disease	
Osteoporosis		Fracture		Clotting disorder	
Cancer (Type)					
Add others/Explain:					

SOCIAL HISTORY

Personal Profile
Occupation: _____ Preferred Language: _____
Birth Place: _____ Ethnicity: _____
£Married £ Single £ Divorced £ Widowed £ Significantly Involved £ Domestic Partner
Exercise: £Yes £ No How often _____ Type: _____
Special Diet: £Yes £No Type: _____
Education Level: £High school £ College £ Graduate degree £ Other
Habits
Smoking: £Yes £ No Packs/day _____ Years _____ Quit when: _____
Alcohol: £Yes £ No Drinks/day _____ Drinks/week: _____ Quit when: _____
Drug Use: £Yes £ No Type _____ Years _____ Quit when: _____
Caffeine: £Yes £ No Cups per day _____ Cups per week: _____
Do you use seatbelts? £Yes £ No Do you use sunscreen? £Yes £ No
Personal Safety
£Yes £ No Has anyone close to you ever threatened to hurt you?
£Yes £ No Has anyone ever hit, kicked, choked or hurt you physically?

Has anyone, including you partner, every forced you to have sex? £ Yes £ No
 Are you ever afraid of your partner? £ Yes £ No

REVIEW OF SYSTEMS (CURRENT SYMPTOMS)

1. CONSTITUTIONAL	7. GENITOURINARY
Fever £	Abnormal Bleeding £
Chills £	Vaginal discharge/ odor £
Fatigue £	Vaginal itching/ burning £
Weight Loss £	Pelvic pain £
Weight gain £	Menstrual cramps £
2. EYES	Painful intercourse £
Changes in vision £	Genital lump £
Double vision £	Fertility concerns £
3. ENT/ MOUTH	Menopausal concerns £
Ear aches £	8. MUSCULOSKELETAL
Ringing in the ears £	Muscle weakness £
Sinus problems £	Joint stiffness £
Sore throat £	Joint pain £
Mouth sores £	Joint swelling £
Dry Mouth £	9. SKIN/ BREAST
4. CARDIOVASCULAR	Breast pain £
Chest pain £	Nipple discharge £
Difficulty breathing on exertion £	Breast lumps £
Swelling of legs £	Rash £
Palpitations £	Ulcers £
Heart Murmurs £	11. PSYCHIATRIC
5. RESPIRATORY	Depression £
Wheezing £	Mood swings £
Spitting up blood £	Anxiety £
Shortness of breath £	Suicidal thoughts £
Cough £	Homicidal thoughts £
6. GASTROINTESTINAL	12. ENDOCRINE
Diarrhea £	Abnormal thirst £
Constipation £	Hot flashes £
Nausea/vomiting £	Tremors £
Bloody stool £	Cold/ heat intolerance £
Abdominal pain £	13. HEMATOLOGIC
Indigestion £	Frequent bruising £
Bloating £	Cuts do not stop bleeding £
Liver problem/Hepatitis £	Enlarged lymph nodes £
7. GENITOURINARY	
Blood in urine £	
Pain with urination £	
Urgency £	
Urinary Frequency £	
Urinary Incontinence £	