HISTORY FORM

Name:_____Today's Date: _____Primary Doctor:_____
Date of Birth:_____Age:_____
Spouse/Partner:_____How long with current partner:_____
CIRCLE the gender of your partner: Male Female
Medical Allergies/Reactions:_____
_____
Current Medications/Dose (including over the counter medications and supplements): _____
_____
First day of last menstrual period: _____
Any specific concerns you would like to address today? _____
_____
Any changes in health since your last annual exam? _____

Review of Systems: Please **CIRCLE** if you **currently** have any of the below symptoms:

- **Constitutional:** fever, chills, sweats, increase/decrease in weight or appetite, fatigue, malaise
- **Cardiovascular:** lightheadedness, palpitations, swelling of legs/ankles, chest pain
- **Respiratory:** cough, sputum, shortness of breath with or without activity
- **Intestinal:** dyspepsia, nausea, vomiting, change in bowel movements (frequency, size or shape), black stools, blood in stools, diarrhea, constipation, abdominal pain, jaundice
- **Urinary:** increased frequency of urination, painful urination, getting out of bed to urinate, loss of urine with cough or sneeze, blood in the urine, sudden urge to urinate, slow stream, incomplete emptying
- **Muskuloskeletal:** stiff joints, neck pain, back pain
- **Skin:** rash, new or unusual skin lesion, changed mole
- **Breast:** lump, nipple discharge, pain
- **Neurologic:** headaches, seizures
- **Pyschologic:** anorexia, anxiety, mood swings, depression
- **Endocrinology:** excessive urination, excessive thirst, fertility issues, temperature intolerance
- **Hematology:** easy bruising, excessive bleeding from nose/gums/cuts, abnormal lymph nodes

Please check if you have had any changes to the following since your last exam.

	Sexually transmitted diseases		Sexual Problem
	Abnormal pap		Endometriosis
	Infertility		Pelvic Prolapse
	Cancer		

FAMILY HISTORY
(Please check if you have had any family history of the problems listed below)

	Heart Attack		Blood clots		Thyroid Disease		Osteoporosis
	Stroke		Hypertension		Birth Defects		Diabetes

Cancer

	Breast		Colon
	Uterine		Ovarian

PREGNANCY HISTORY

YEAR	DURATION (MOS/WEEKS)	LABOR LENGTH	WEIGHT	SEX	DELIVERY TYPE	HOSPITAL	COMPLICATIONS