

Health History Update

NAME _____ DATE _____

What new medical conditions have you had since your last exam? NONE

What surgeries have you had since last exam with us? List surgery type, when, & where? NONE

Do You have any family members with new medical conditions/cancer since your last exam? NONE

Please list family member, age of diagnosis, and diagnosis

Family Member	Age	Diagnosis

Have you had a Hysterectomy? If Yes skip this section

When was the first day of your last period?	____/____/____	Any Other concerns?
How long are your cycles in days?		
How long does your period last?		
Are your periods regular?	YES <input type="checkbox"/> NO <input type="checkbox"/>	
Any problems with your periods?	YES <input type="checkbox"/> NO <input type="checkbox"/>	

Alcohol?	Yes			No		
Drinks per?	Daily:	Weekly:	Monthly:			
Drug Use?	Yes			No		
Types? Present or Past?						
Caffeine?	Yes			No		
Drinks per?	Daily:	Weekly:	Monthly:			
Currently Smoking?	Yes			No		
Packs Per Day?						
# of Years?						
Have you ever been a smoker?	Yes			No		
If so, how many years?						
What is your Occupation?						
How much do you exercise? Per week	None	1X	2-3X	4x or more		
History of Abuse?	Yes			No		
Type?	Sexual	Emotional		Physical		
Do you use your seatbelt?	Yes			No		
Marital Status?	Single	Engaged	Married	Divorced		
	Domestic Partner		Separated	Widowed		
Are you sexually active at this time?	Yes			No		
Type?	Men	Women		Both		

Review of Systems

Name: _____

If you are currently experiencing any of these symptoms, please circle the symptom

Constitutional	Fatigue Weight Changes Night Sweats Hot Flashes Fever Body Aches Chills Change of Appetite Additional Symptoms: _____
Eyes	Vision Changes Discharge Discomfort Pain Double Vision Blurred Vision Eyelid Lesion Additional Symptoms: _____
HENT	Headaches Neck Tenderness Dizziness Lightheadedness Nasal Congestion Nose Bleeding Nasal Discharge Postnasal Drip Sinus Pain Hoarseness Neck Stiffness Neck Pain Thyroid Mass Oral Ulcers Sore Throat Breath Odor Decreased Hearing Tinnitus Additional Symptoms: _____
Breast	Lumps Tenderness Swelling Redness Nipple Discharge Additional Symptoms: _____
Cardiovascular	Lightheadedness Irregular Heartbeat Chest Pain Rapid Heart Rate Lower Extremity Edema Additional Symptoms: _____
Respiratory	Shortness of Breath Wheezing Cough Hoarseness TB Exposure Additional Symptoms: _____
Gastrointestinal	Nausea Vomiting Diarrhea Constipation Loss of Appetite Heartburn Reflux Retching Excessive Bleeding Jaundice Abdominal Pain Blood in Stools Hemorrhoids Fatty Stools Excessive Flatulence Additional Symptoms: _____
Genitourinary	Urgency of Urine Frequent Urination Painful Urination Incontinence Vaginal Discharge Decreased Libido Irregular Menses Possible Pregnancy Genital Sores PMS Symptoms Change in Urine Color Difficulty Voiding Additional Symptoms: _____
Integument	Rash Itching Pigmentation Changes Acne Skin Dryness Hair Growth Change Nail Changes New Skin Lesions Changes to Existing Skin Lesions Additional Symptoms: _____
Neurological	Seizures Tingling/Numbness Muscular Weakness Snoring Incoordination Loss of Balance Difficulty Concentrating Speech Difficulties Memory Difficulties Additional Symptoms: _____
Musculoskeletal	Joint/Pain Swelling Muscle Pain Limitation of Motion Muscle Cramps Muscular Weakness Additional Symptoms: _____
Endocrine	Loss of Hair Constipation Increased/Decreased Libido Acne Cold/Heat Intolerance Additional Symptoms: _____
Psychiatric	Anxiety Depression Difficulty Sleeping Delusions Hallucinations Feeling Confused Compulsive Behaviors Impulsive Behaviors Suicidal Ideation Homicidal Ideation Excessive Anger Additional Symptoms: _____
Heme/Lymph	Lightheadedness Easy Bleeding Easy Bruising Lymph Node Enlargement Additional Symptoms: _____
Allergic/ Immunologic	Sinus Allergy Symptoms Frequent Illnesses Additional Symptoms: _____