

Name: _____

Date: _____

	Now	Past	Physician's Notes
1. Constitutional			
Weight loss			
Weight gain			
Fatigue			
2. Eyes			
Vision changes			
3. Ear, Nose, and Throat			
Hearing problems			
Sinus problems			
Sore throat			
4. Cardiovascular			
Painful breathing			
Chest pain or pressure			
Swelling of legs			
5. Respiratory			
Shortness of breath			
Chronic cough			
6. Gastrointestinal			
Diarrhea			
Bloody stool			
Nausea/vomiting			
Constipation			
7. Genitourinary			
Blood in urine			
Pain with urination			
Frequent urination			
Urine loss when coughing or lifting			
Abnormal bleeding			
Painful periods			
Premenstrual syndrome (PMS)			
Painful intercourse			
History of fibroids			
Infertility			
DES exposure			
Abnormal vaginal discharge			
Sexually transmitted disease			
Abnormal papsmear results			
8. Musculoskeletal			
Muscle or joint pain			
9a. Skin			
Unusual moles			
9b. Breasts			
Pain in breast			
Nipple discharge			
Lumps			
10. Neurologic			
Seizures			
Trouble walking			
Severe memory problems			
Frequent or severe headaches			
11. Psychiatric			
Depression or frequent crying			
Severe anxiety			

	Now	Past	Physician's Notes
12. Endocrine			
Hair loss			
Heat/cold intolerance			
Abnormal thirst			
Hot flashes			
13. Hematologic/Lymphatic			
Frequent bruises			
Cuts don't stop bleeding			
14. Allergic/Immunologic			
MEDICATION ALLERGIES/OTHER ALLERGIES			
Please list allergy and reaction:			
Please list current medications:			

DISEASES & VACCINES	Had Condition?		Vaccine Dates:
MMR (Measles, Mumps, Rubella)	Y	N	
Chicken Pox	Y	N	
Hepatitis B	Y	N	1. 2. 3.
Pneumavax			
DTAP (Diphtheria, Tetanus & Pertussis)			

PAST MEDICAL PROBLEMS:

Type	Date

PREVIOUS SURGERIES:

	Date

OBSTETRICAL HISTORY

Number of Pregnancies: _____ Number of Deliveries: _____ Number of Miscarriages: _____

	DELIVERY DATE	GESTATIONAL AGE	INFANT WT	LENGTH OF LABOR	ROUTE	FACILITY	SEX	COMPLICATIONS	NAME
1									
2									
3									
4									
5									

SOCIAL HISTORY

Date of last papsmear: _____ Result: _____
 Date of last mammogram: _____ Result: _____
 Last menstrual period: _____ Age of 1st Period: _____ # of Sex Partners _____
 Are you sexually active? _____ Birth Control Method: _____
 Any history of tobacco use: _____ Packs/Day: _____ No. of Years: _____ Have you quit? _____
 Any history of alcohol use: _____ How many drinks per week: _____
 Any history of illicit drug use: _____ Explain: _____
 Any history of sexual or physical abuse? _____

LABOR	ROUTE	FACILITY	SEX	COMPLICATIONS	NAME