Specialists in Prevention Diagnosis and Treatment of Adult Illness

FEMALE HISTORY

(Returning patients may update as needed since last complete exam)

Exam Date: ________________
Name: ____ Date of Birth: ________________

CHECK ONE:
□ Married □ Single □ Widowed
□ Divorced □ Living Together

Occupation/Employer: ____ Highest Level of Education: __________________

HOSPITALIZATIONS IF YOU HAVE BEEN IN THE HOSPITAL OVERNIGHT | STATE THE YEAR | ILLNESS/OPERATION (DOES NOT INCLUDE NORMAL PREGNANCIES)

YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

MEDICAL HISTORY MARK **C** FOR CURRENT PROBLEM; MARK **X** AND INDICATE AGE WHEN YOU HAD ANY OF THE FOLLOWING SYMPTOMS OR PROCEDURES.

LIST MAIN PROBLEMS: 1) _______________________ 2) ________________________ 3) ___________________________

___ Decreased Hearing
___ Ringing in Ear
___ Ear Infections – Frequent
___ Dizzy Spells
___ Failing Visions
___ Double or Blurred Vision
___ Eye Pain ___ Eye Disease
___ Eye Infections – Frequent
___ Nose Bleeds – Recurring
___ Sinus Trouble
___ Frequent Sore Throats
___ Allergies/Hay Fever
___ Hoarseness – Prolonged
___ Pneumonia ___ Lung Disease
___ Bronchitis/Chronic Cough
___ Asthma/Wheezing
___ Shortness of Breath
___ On Exertion ___ Lying Flat
___ High Cholesterol
___ Chest pain ___ Angina
___ High Blood Pressure
___ Heart Murmur ___ Heart Attack
___ Palpitations
___ Heart Valve Disease
___ Irregular Pulse
___ Swollen Ankles
___ Fainting Spells

___ Leg Pain when Walking
___ Varicose Veins/Phlebitis
___ Loss of Appetite – Recent
___ Difficulty Swallowing
___ Indigestion/Heartburn
___ Persistent Nausea/Vomiting
___ Peptic Ulcers
___ Abdominal Pain – Chronic
___ Change in Bowel Habits-Recent
___ Diarrhea
___ Constipation
___ Diverticulosis
___ Bloody or Tarry Stools
___ Hemorrhoids
___ Gall Bladder Trouble
___ Jaundice/Hepatitis
___ Hernia
___ Urine Infections – Frequent
___ Painful Urination
___ Blood in Urine
___ Overnight Urination (2+)
___ Control in Urination
___ Decrease in Force Urination
___ Kidney Stones
___ Other Kidney/Bladder Infections
___ Venereal Disease
___ Urethral Discharge

___ Bleeding Disorder
___ Chronic Fatigue
___ Weight Loss – Recent
___ Anemia ___ Bruise Easily
___ Cancer
___ Diabetes
___ Thyroid Disease
___ Convulsions/Seizures
___ Stroke
___ Tremor/Hands Shaking
___ Muscle Weakness
___ Neurological
___ Numbness/Tingling Sensations
___ Headaches – Frequent
___ Migraines
___ Arthritis/Rheumatism
___ Back Pain – Recurring
___ Bone Fracture/Joint Injury
___ Gout ___ Osteoporosis
___ Foot Pain ___ Cold Numb Feet
___ Rashes ___ Hives
___ Psoriasis ___ Eczema
___ Sleeping – Difficulty
___ Nervousness ___ Depression
___ Memory Loss
___ Moodiness – Excessive
___ Phobias

___ Mental Illness
___ Alcoholism
___ Blood Transfusion
___ Chicken Pox
___ Polio
___ Measles
___ Mumps
___ German Measles
___ Tuberculosis
___ Rheumatic Fever
___ Scarlet Fever

Other Symptoms of Disease
____
____
____

DATE OF LAST MENSTRUAL PERIOD
____
ARE YOU USING BIRTH CONTROL?
□ YES □ NO
____ NUMBER OF PREGNANCIES
____ NUMBER OF LIVE BIRTHS
____ NUMBER OF ABORTIONS
____ NUMBER OF MISCARRIAGES
____
DATE OF LAST:
Pap Test ____________ □ NORM □ ABN
Breast Exam _________ □ NORM □ ABN
Mammogram ________ □ NORM □ ABN
ARE YOU DOING SELF BREAST EXAMS?
□ YES □ NO ____ per Month
OTHER _________________________

FAMILY HISTORY IF ANY BLOOD RELATIVE HAS SUFFERED ANY OF THE FOLLOWING, INDICATE WHICH RELATIVE.

□ Tuberculosis _________________
□ Stroke _____________________
□ Migraine____________________
□ Mental Illness _______________
□ Allergy _____________________
□ Hypertension ________________
□ Epilepsy _________________

□ Diabetes _____________________
□ Cancer _______________________
□ Glaucoma ____________________
□ Heart Attack __________________
□ Arthritis/Gout _________________
□ Lung Disease __________________
□ Kidney Disease ________________

□ Other _______________________
____
____

DO YOU NOW OR HAVE EVER

CURRENT SMOKER □ YES □ NO
FORMER SMOKER QUIT DATE __________________
DRINK ALCOHOL □ YES □ NO DRINKS/WK ______
DRINK COFFEE/TEA □ YES □ NO CUPS/DAY _____
USE(D) STREET/ILLEGAL DRUGS □ YES □ NO
TYPE: ________________________________

DRUG ALLERGIES

DRUG	REACTION
_______________	_______________
_______________	_______________
_______________	_______________
_______________	_______________

LIST OF ALL MEDICATIONS YOU NOW TAKE

MEDICATION	DOSE	DAY
______________________________	_____	_____
______________________________	_____	_____
______________________________	_____	_____
______________________________	_____	_____
______________________________	_____	_____
______________________________	_____	_____
______________________________	_____	_____
______________________________	_____	_____
______________________________	_____	_____
______________________________	_____	_____
______________________________	_____	_____
______________________________	_____	_____
______________________________	_____	_____

HEALTH HABITS

DO YOU EXERCISE? □ YES □ NO
TYPE: ________________________________
DURATION: ___________ FREQUENCY: _________
OTHER: ________________________________
USE SUNSCREEN? □ YES □ NO
EXAMINE SKIN FOR CHANGES? □ YES □ NO
USE SEAT BELTS? □ YES □ NO

THE LAST TIME YOU HAD

FLU SHOT _______ TETANUS SHOT __________
HEPATITIS VACC _______ PNEUMONIA SHOT _______
RECTAL EXAM ________ T.B. TEST ____________
STOOL BLOOD TEST _______ SIGMOID EXAM _______
EYE EXAM ____________ DENTAL EXAM __________
CHOLESTEROL TEST __________ RESULTS _________
____

ARE YOU HAVING ANY SYMPTOMS OR PROBLEMS THAT YOU WOULD LIKE TO DISCUSS? *PLEASE LIST THEM*

DO YOU HAVE ANY OTHER MEDICAL PROBLEMS FOR WHICH YOU HAVE BEEN SEEING A DOCTOR ON A REGULAR BASIS? *PLEASE LIST THEM*