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Initial review: _____

Other reviews _____

_____

_____

Your Name _____ Acct No. _____

Today's date _____ Who is your family Doctor? _____

All women:

When was your last pap smear? _____ When was your last mammogram? _____
When was your last bone mineral density (BMD) study? _____

Do you have a vaginal discharge? _____
If yes, How long have you had it? _____ What color is it? _____ Does it have a bad odor? _____ Does it cause any burning or itching? _____ Could you have been exposed to a sexually transmitted disease? _____ When was your last vaginal infection? _____ What kind of infection was it? _____

Do you have any burning or pain with emptying your bladder? _____
If yes, How long have you had it? _____ Do you have blood in your urine? _____
When was your last bladder infection? _____

Do you have any pelvic pain? _____ Do you have any abnormal bleeding? _____
Do you have a lump in your breast? _____ Any breast pain? _____ __ Have you had any female surgery? _____

Pre-menopause women:
What do you do to prevent pregnancy? _____ When was your last menstrual period? _____
How many days are between your menstrual cycles? _____ How many days do you bleed? _____
On a scale of 1 (light) to 5 (heavy), what is your bleeding like? _____
How many days are heavy? _____ How often do you change protection on the heavy days? _____
On a scale of 1 (mild) to 5 (severe), what are your cramps like? _____ How many days do you have severe cramps? _____ What medicines do you take for the cramps? _____ How many pills do you take a month for the cramps? _____

Post-menopause women:
What year did you go through the menopause? _____ How old were you? _____
Have you taken hormones for the menopause? _____
If yes, for how many years? _____ Do you now take hormones? _____ What is the name of your hormone pill? _____

Review of Symptoms: (Please circle any symptoms which you NOW have)

General:
- excessive fatigue
- insomnia
- weight gain or loss
- allergies

Head and Neck:
- frequent headaches
- frequent colds
- swelling in neck

Heart:
- heart problems
- high blood pressure
- chest pain
- irregular heart beats

Lungs::
- shortness of breath
- wheezing
- chronic cough
- asthma

Stomach & Intestines:
- heartburn
- vomiting
- constipation
- diarrhea
- blood in bowel movements

Urinary Tract::
- unintentional loss of urine
- blood in urine
- pain with emptying bladder

Muscles & Joints:
- bone or joint pain
- back pain
- arthritis
- difficulty moving arms or legs
- muscle pain

Neuropsychological:
- PMS
- menopause symptoms
- depression
- personality change
- psychotherapy or counseling

Skin:
- rash
- cysts or tumors
- unusual mole

Past Medical History:

List all of your pregnancies:

Date Vaginal/cesarean section sex of baby

_____
_____
_____
_____

List all of your surgeries:

Date Type of surgery

_____
_____
_____
_____

List all of your medical illnesses and how long you have had this illness:

_____
_____
_____
_____
_____

List your medicines:

_____
_____
_____
_____
_____
_____

List all of your allergies (medicines and environmental(:

_____
_____

Social History:

Where do you work? _____
What do you do? _____
Who lives in your household? _____
_____
_____
Do you smoke? _____
How many packs a day? _____

Family History:

Relation Illness

Spouse _____
Children _____
_____
_____
Father _____
Mother _____

Other Information:

_____
_____
_____
_____
_____
_____

Signature: _____ Date: _____