DATE:_____ **NAME:**_____ **D.O.B.**_____ **AGE:**_____

BP: **P:** **PO2:** **HT:** **WT:** **BMI:** **TEMP:**

If your name, address, phone number, or emergency contact has changed since your last visit please note changes here:
☐No Changes

What is the reason for your visit today? If here for a problem, is this a new problem? ☐YES ☐NO

If here for a problem, where is it, how severe is it, when did it start?

If here for a problem, what makes it better, what makes it worse?

Have you been treated for this problem before? ☐YES ☐NO
If yes, where/when?

Date of first day of last menstrual period?
☐Hysterectomy ☐Menopause ☐Mirena/Skyla ☐Uterine Ablation

Date of last Pap smear? Date of last mammogram? Date of last Colonoscopy?

CURRENT MEDICATIONS: List prescriptions, hormones, vitamins, herbs, non-prescription medications & supplements

Name of Medication	Dose & How often used	Month & Year Began Taking	Who Prescribed

CURRENT BIRTH CONTROL:

☐None ☐Seeking pregnancy or pregnant ☐Abstained ☐Withdrawal ☐Condoms ☐Outer-course (no penetration)
☐Condoms ☐Vasectomy ☐Tubal Ligation/Essure ☐Natural family planning - rhythm ☐Diaphragm ☐Injection/Shot
☐Pills ☐Patch ☐Ring ☐Implant: Implanon/Nexplanon ☐IUD: Mirena/Skyla/Paragard

ALLERGIES: LIST ALL ALLERGIES TO MEDICATIONS AND FOOD

☐No Known Allergies
☐YES, I am allergic to LATEX
☐YES, see my list of allergies and reactions below

Allergic To:	**Reaction:**

List any new medical problems since last visit:
☐None

List any new surgeries since last visit:
☐None

List hospitalizations since last visit:
☐None

List any changes in family medical history since last visit:
☐None

☐Yes, problems with accidental or uncontrolled leaking of urine?
☐Yes, problems with accidental or uncontrolled bowel movements?
☐Yes, problems with painful sex, decreased sex drive, inability to orgasm, lubrication?

DATE:_____ NAME:_____ D.O.B._____ AGE:_____

Instructions: Check any CURRENT PROBLEMS that you are experiencing now:

	GENITOURINARY GYN
☐	Pain when urinating
☐	Frequent urination
☐	Strong urgency to urinate
☐	Difficulty urinating
☐	Bladder not emptying
☐	Blood in urine
☐	Leaking urine, incontinence
☐	Genital sores
☐	Abnormal vaginal discharge
☐	Vaginal itching, burning
☐	Vaginal odor
☐	Vaginal mass, protrusion
☐	Abnormal vaginal bleeding
☐	Abnormal periods
☐	Painful periods
☐	Premenstrual syndrome PMS
☐	Pelvic pain
☐	Painful intercourse
☐	Low sex drive, libido
☐	Problems getting pregnant
☐	

	BREAST & SKIN
☐	Breast pain
☐	Breast lump, mass
☐	Nipple discharge
☐	Rashes or hives
☐	Sores, boils, abscess, acne
☐	Abnormal moles or warts
☐	Dry, scaly, skin or plaques
☐	

	CONSTITUTIONAL
☐	Weakness, unusual fatigue
☐	Fever
☐	Unintentional weight loss
☐	Abnormal weight gain
☐	Lack of appetite, anorexia
☐	Night sweats

	EYES
☐	Vision changes, problems
☐	Wear glasses or contacts
☐	

	EARS, NOSE, THROAT
☐	Ear pain
☐	Ringing ears
☐	Hearing difficulties
☐	Nose bleeds
☐	Congestion or runny nose
☐	Mouth, gum, tongue sores
☐	Sore throat, voice change
☐	

	CARDIOVASCULAR
☐	Chest pain or pressure
☐	Shortness of breath
☐	Difficulty breathing
☐	Feel irregular heart beats
☐	Swelling (edema)
☐	

	PULMONARY
☐	Wheezing
☐	Cough
☐	Coughing up blood
☐	Short of breath
☐	Painful breathing
☐	

	GASTROINTESTINAL
☐	Diarrhea
☐	Constipation
☐	Abdominal pain
☐	Gas, bloating
☐	Bloody stool or rectal bleed
☐	Nausea, vomiting
☐	Heart burn
☐	Leaking stool, incontinence
☐	

	PSYCHIATRIC
☐	Depressed mood
☐	Excessive anxiety
☐	Extreme mood swings
☐	Sleep disturbances
☐	Unusual behaviors
☐	Ideas of hurting self, others
☐	Hearing or seeing things
☐	

	MUSCULOSKELETAL
☐	Muscle weakness
☐	Muscle pain or stiffness
☐	Joint pain or stiffness
☐	Back pain
☐	Limited movement
☐	

	ENDOCRINE
☐	Heat intolerance
☐	Cold intolerance
☐	Excessive thirst & urination
☐	Hair loss
☐	Hot flashes / night sweats
☐	Weight changes
☐	

	NEUROLOGIC
☐	Dizziness or fainting
☐	Tremors
☐	Seizures
☐	Numbness, tingling
☐	Trouble with balance, walking
☐	Unusual memory loss
☐	Frequent or severe headache
☐	

	HEMATOLOGIC / LYMPH
☐	Abnormal bruising
☐	Prolonged bleeding from cuts
☐	Enlarged glands, lymph node
☐	

NOTES & SIGNATURES