

INTERVAL HISTORY

Name: _____ Date of Last Physical: _____ Today's Date: _____
 D.O.B.: _____

ADVANCED DIRECTIVE: Do you have an Advanced Directive/ Durable Power of Attorney for health care? Yes No

MEDICAL HISTORY

Please list all other doctors you see and the reason(s) you see them: _____

Any new diagnoses, hospitalizations, medical problems or surgeries since last physical: _____

CURRENT MEDICATIONS: List all current medications or any supplements/vitamins you are currently taking.

Medication	Dose	How often you take it	What you take it for	When it was started	Refill needed?

WOMEN'S HEALTH:

Date of last pap test:	Ever had an abnormal pap: <input type="checkbox"/> No <input type="checkbox"/> Yes, dates: _____ Treatment: _____
Form of birth control:	Menstrual cycles are: <input type="checkbox"/> Regular <input type="checkbox"/> Irregular, explain: _____ <input type="checkbox"/> Menopause at age: _____
Date of last mammogram:	Date of last bone density test: _____

FAMILY HISTORY

Any colon, breast, ovarian or prostate cancer? Heart disease, high blood pressure, diabetes, melanoma or other medical problems? List which member of the family is affected and their age at diagnosis: _____

SOCIAL HISTORY:

Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Occupation: _____
Exercise (type, frequency)		
Tobacco	<input type="checkbox"/> Yes <input type="checkbox"/> Smoked in past, quit in _____ . # of packs per day _____ . # of years _____	Ready to quit? _____
Alcohol	# glasses/day _____ per week _____ . Problems due to alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes, explain: _____	
Recreational Drugs	<input type="checkbox"/> No <input type="checkbox"/> Yes, please explain: _____	Ready to quit? _____
Domestic Violence	Are you involved in domestic violence <input type="checkbox"/> No <input type="checkbox"/> Yes, please explain _____	

REVIEW OF SYSTEMS: Please check if you have any of the symptoms below regularly or out of the ordinary.

Constitution	Endocrinology	Gastroenterology	Neurology	Psychiatry
<input type="checkbox"/> blurring of vision	<input type="checkbox"/> excessive thirst	<input type="checkbox"/> abdominal pain	<input type="checkbox"/> dryness	<input type="checkbox"/> redness
<input type="checkbox"/> headache	<input type="checkbox"/> cold intolerance	<input type="checkbox"/> sudden blindness	<input type="checkbox"/> rash	<input type="checkbox"/> cramps
<input type="checkbox"/> dizziness	<input type="checkbox"/> heat intolerance	<input type="checkbox"/> double vision	<input type="checkbox"/> vomiting	<input type="checkbox"/> muscle/tendon injury
<input type="checkbox"/> fainting	<input type="checkbox"/> chest pain	<input type="checkbox"/> Endocrinology	<input type="checkbox"/> diarrhea	<input type="checkbox"/> changing/new mole
<input type="checkbox"/> fatigue	<input type="checkbox"/> palpitations	<input type="checkbox"/> Urology	<input type="checkbox"/> bloody or black stool	<input type="checkbox"/> Neurology
<input type="checkbox"/> weight change	<input type="checkbox"/> cough	<input type="checkbox"/> Cardiology	<input type="checkbox"/> constipation	<input type="checkbox"/> paralysis
<input type="checkbox"/> fever	<input type="checkbox"/> wheeze	<input type="checkbox"/> Ears/nose/throat	<input type="checkbox"/> jaundice	<input type="checkbox"/> numbness
<input type="checkbox"/> Ears/nose/throat	<input type="checkbox"/> shortness of breath	<input type="checkbox"/> Cardiology	<input type="checkbox"/> weakness	<input type="checkbox"/> depression
<input type="checkbox"/> hearing loss	<input type="checkbox"/> chronic phlegm	<input type="checkbox"/> Urology	<input type="checkbox"/> convulsions	<input type="checkbox"/> insomnia
<input type="checkbox"/> ringing in the ears	<input type="checkbox"/> chronic phlegm	<input type="checkbox"/> Urology	<input type="checkbox"/> erectile dysfunction	<input type="checkbox"/> anxiety
<input type="checkbox"/> loss of balance	<input type="checkbox"/> coughing up blood	<input type="checkbox"/> Hematology/Lymph	<input type="checkbox"/> burning	<input type="checkbox"/> Women's Health
<input type="checkbox"/> nose bleeds	<input type="checkbox"/> dermatology	<input type="checkbox"/> Hematology/Lymph	<input type="checkbox"/> increased frequency	<input type="checkbox"/> spotting
<input type="checkbox"/> chronic drainage	<input type="checkbox"/> dermatology	<input type="checkbox"/> Hematology/Lymph	<input type="checkbox"/> bloody or dark urine	<input type="checkbox"/> painful intercourse
<input type="checkbox"/> sore throat	<input type="checkbox"/> dermatology	<input type="checkbox"/> Hematology/Lymph	<input type="checkbox"/> swollen glands	<input type="checkbox"/> severe cramps
<input type="checkbox"/> difficulty swallowing	<input type="checkbox"/> dermatology	<input type="checkbox"/> Hematology/Lymph	<input type="checkbox"/> frequent back pain	<input type="checkbox"/> breast lumps or pain
<input type="checkbox"/> Eyes	<input type="checkbox"/> dermatology	<input type="checkbox"/> Hematology/Lymph	<input type="checkbox"/> sciatica	<input type="checkbox"/> excessive bleeding
<input type="checkbox"/> coughing up blood	<input type="checkbox"/> dermatology	<input type="checkbox"/> Hematology/Lymph	<input type="checkbox"/> extremity swelling	<input type="checkbox"/> breast discharge
<input type="checkbox"/> dermatology	<input type="checkbox"/> dermatology	<input type="checkbox"/> Hematology/Lymph	<input type="checkbox"/> vaginal discharge	<input type="checkbox"/> breast discharge

IMMUNIZATIONS: Please check the box and write in the dates if you have had any of the vaccines below.

Vaccine	Date Given	Vaccine	Date Given
<input type="checkbox"/> Influenza (Flu shot)		<input type="checkbox"/> Pneumococcal (Pneumonia)	
<input type="checkbox"/> Human papillomavirus (Gardasil)		<input type="checkbox"/> Tetanus, diphtheria, pertussis (whooping cough)	
<input type="checkbox"/> Meningococcal (Meningitis)		<input type="checkbox"/> Zoster (Shingles)	

OTHER CONCERNS YOU WOULD LIKE TO DISCUSS: _____

