Name ________________________ **Age** ________ **Date** ____________________

Primary Care Physician ______________________________

CC: What is the reason for this visit? ______________________________

Any other problems to discuss with the doctor? ______________________________

List prescriptions that need to be refilled: ______________________________

PMH: Since your last annual exam have you had:

	NO	YES		
Any surgeries?	☐	☐	What? ____________	When? ________
Any hospitalizations?	☐	☐	What? ____________	When? ________
New illnesses or medical diagnoses?	☐	☐	What? ____________	When? ________
Injuries?	☐	☐	What? ____________	When? ________

Please list your current medications (including non-prescription), vitamins, and herbs: ______________________________

____

FH: Any change in your family's medical history since last annual exam? ___NO ___YES What? ____________

SOCHX:

	NO	YES	
Do you smoke?	☐	☐	How much? ____________
Do you drink alcohol?	☐	☐	How much? ________ drinks per day / week / month (circle one)
Do you drink caffeine?	☐	☐	How much? ________ cups or glasses per day / week (circle one)
Do you get calcium in your diet?	☐	☐	
Or in a supplement?	☐	☐	
Do you exercise?	☐	☐	How much? ____________
Do you live alone?	☐	☐	If not, with whom? ____________

HPI: Date of last menstrual period/ year of menopause ____________

		NO	YES
Are you having any:	vaginal bleeding?	☐	☐
	pelvic pain?	☐	☐
	irritating vaginal discharge?	☐	☐
	vulvar itching or rashes?	☐	☐
Are you sexually active?		☐	☐
If so, are you having any pain with sex?		☐	☐
	Bleeding with sex?	☐	☐
Do you have any breast pain?		☐	☐
Have you noticed a new breast lump?		☐	☐

Status of chronic conditions: ______________________________

____

____

ROS: Please check off the symptoms that you are experiencing or have recently experienced. If you are not having any symptoms, check none.

CONST: ___Weight loss ___Weight gain ___Fever ___Fatigue ___NONE

HEENT: ___Sore throat ___Sinus infection ___Ringing in ears ___Headache ___NONE

CV: ___Chest pain ___Palpitations ___Leg swelling ___Difficulty breathing lying down ___NONE

RESP: ___Wheezing ___Cough ___Coughing up blood ___Shortness of breath ___NONE

GI: ___Diarrhea ___Constipation ___Bloody stools ___Abdominal pain ___Nausea/Vomiting ___NONE

GU: ___Painful urination ___Blood in urine ___Urgency ___Frequency ___Incontinence/Loss of urine ___NONE

MS: ___Muscle weakness or pain ___Joint pain ___Broken bones ___NONE

NEURO: ___Fainting ___Seizures ___Dizzy spells ____Numbness ___NONE

PSY: ___Depression ___Anxiety ___NONE

HMLYM: ___Swollen lymph nodes ___Easy bruising ___NONE

ALL: ___New Medicine allergies, please list ____________ ___Other allergies ___NONE