| Name: | Date of Birth: |
|---|---|
| **Date of LMP:** | |

**Current Medications (include hormones, herbs, vitamins, nonprescription medicine)**

| Name and Dosage | Name and Dosage |
|---|---|
| 1. | 4. |
| 2. | 5. |
| 3. | 6. |

**Allergies (Please include all drug allergies)**

| | |
|---|---|
| 1. | 3. |
| 2. | 4. |

**What is your problem today:**

**Describe your problem- Location/Quality/Severity/Duration/Timing/Context/Modifying Factors/Assoc signs & Symptoms:**

**System Review**
**Please answer each category**

| | | | | | | |
|---|---|---|---|---|---|---|
| **General** | None | Fever | Chills | Sweats | Loss of Appetite | Fatigue |
| | | Generally feel badly | Weight loss | | | |
| **ENT** | None | Earache | Hoarseness | Ringing In ears | Decreased hearing | |
| | | Nasal congestion | Nosebleeds | Sore throat | Difficulty swallowing | |
| **Heart** | None | Chest pains | Palpitations | Fainting Spells | Difficulty breathing when lying flat | |
| | | Out of breath exertion | Short of breath at night | | Swelling in legs | |
| **Lung** | None | Cough | Shortness of breath | | Excessive sputum | |
| **Gastro** | None | Nausea | Vomiting | Diarrhea | Constipation | |
| | | Change in bowel habits | Abdominal pain | Black/tarry Stools | Jaundice | Vomiting blood |
| **Urinary** | None | Leaking urine with cough or sneeze | | Leaking urine without cough or sneeze | | |
| | | Burning with urination | Blood in urine | Urinary frequency | | |
| **Breasts** | None | Pain | Lump | Discharge | | |
| **GYN** | None | Vaginal discharge with itching | | Vaginal discharge with odor | | |
| | | Other vaginal discharge | Pelvic pain | Abnormal vaginal bleeding | | |
| | | Heavy vaginal bleeding | Missed periods | Irregular menses | | |
| **Ortho** | None | Back pain | Joint swelling | Muscle cramps | | |
| | | Muscle weakness | Stiffness | Arthritis | | |
| **Skin** | None | Rash Itching | Dryness | | | |
| **Neuro** | None | Sensation of room spinning | Weakness | Tingling | Seizures | |
| | | Fainting spells | Tremors | | | |
| **Psych** | None | Depression | Anxiety | Memory loss | Mental disturbance | |
| | | Suicidal thoughts | Hallucinations | | | |
| **Endocrine** | None | Cold intolerance | Heat intolerance | Excessive thirst | | |
| | | Excessive hunger | Excessive amounts of urine | | | |
| | | Significant weight loss | Significant weight gain | | | |

| Since Your Last Visit: | Yes | No | Please describe: |
|---|---|---|---|
| Have you been diagnosed with a new medical problem? | | | |
| Have you had any surgeries? | | | |
| Have you been diagnosed with a new medication allergy? | | | |
| Do you have any new family history? | | | |

| Menstrual History | Yes | No |
|---|---|---|
| Are you menopausal? | | |
| Have you had a hysterectomy? | | |
| Are you currently late for your period? | | |
| Are you currently pregnant? | | |
| What was your age at your first menstrual period? | | |
| Date of your last menstrual period: | | |
| Are your periods regular (28-30 days)? | | |
| If No what is the interval between your periods? (Number of days) | | |
| How many days of bleeding do you have? | | |
| How many heavy days? | | |
| Do you have pain with your period? | | |
| If Yes- how bad is that pain? | Minimal Mild Moderate Severe | |
| Do you have a problem with heavy bleeding? | | |
| Do you bleed onto your clothes or bedding? | | |
| Do you bleed after intercourse? | | |
| Do you have bleeding between your periods? | | |
| If Yes- how bad is that bleeding? | Light Medium Heavy | |
| Occurring? | Early Mid-cycle Late Just prior to menses Random | |

| Contraception | Yes | No |
|---|---|---|
| Are you in a sexual relationship? | | |
| Do you have pain with intercourse? | | |
| Are you trying to become pregnant? | | |
| Do you have questions about sexual function, contraception, or infections? | | |
| Permanent Sterilization Method: | Essure Tubal ligation Vasectomy Hysterectomy None | |

| **What type of contraception do you currently use?** | None Essure Tubal ligation Hysterectomy |
|---|---|
| | Abstinence Rhythm Method Male withdrawal Condoms Spermicides Diaphragm |
| | Norplant Pills Patch Ring Shot IUD-Paragard IUD-Mirena Implanon |

| **What type of contraception have you previously used?** | None Abstinence Rhythm Method |
|---|---|
| | Male withdrawal Condoms Spermicides Diaphragm Norplant Pills Patch |
| | Ring Shot IUD-Paragard IUD-Mirena Implanon |