PATIENT ID: Name: (Last, First, MI) _____DOB (MMDDYY) _____

1. **Please explain in detail the reason for your visit today? If you are here for follow up, please give an update on your symptoms. Please explain if your symptoms are improved, the same, or worsened. Include all pertinent information that you can recall to make your visit with your doctor more thorough.**

_____
_____
_____
_____
_____
_____

2. **Are there any changes to your PERSONAL MEDICAL HISTORY since your last visit?**

_____
_____

Illnesses since last visit? Please list major illnesses/when?

_____
_____

Surgeries since last visit? Please list any surgical procedures/dates

_____
_____

3. **Do you take any new medications? Please list all NEW medications including all supplements and over the counter medications.**

_____
_____

4. **Do you want a chaperone for your physical exam today? Circle one: Yes or No _____(initial here)**

REVIEW OF SYMPTOMS: Please check (✓) any current problems you have on the list below.

Constitutional
___Fevers/chills/sweats
___Unexplained weight loss/gain
___Fatigue/weakness

Eyes
___Change in vision

E ars/Nose/Throat/Mouth
___Difficult hearing/Ringing in ears
___Problems with teeth/gums
___Hay fever/allergies

Respiratory
___Cough/wheeze
___Difficulty breathing

Cardiovascular
___Chest pain/discomfort
___Leg pain with exercise
___Palpitations

Gastrointestinal
___Abdominal pain
___Bloody/black bowel movement
___Nausea/vomiting/diarrhea
___Constipation

Genitourinary
___Nighttime urination
___Leaking urine
___Painful urination
___Blood in urine
___Unusual vaginal bleeding
___Sexual function problems

Musculoskeletal
___Muscle/joint pain or swelling

Endocrine
___Excessive thirst or urination

Neurological
___Headaches
___Dizziness/light-headedness
___Numbness
___Memory loss
___Loss of coordination

Psychiatric
___Anxiety/stress
___Problems with sleep
___Depression

Skin
___Rash or mole change

Blood/Lymphatic
___Unexplained lumps
___Easy bruising/bleeding
___Sickle cell disease

For Women: # pregnancies:____ # deliveries:____ # abortions: ____ # miscarriages: _____
1st day, most recent period: _____ Age at 1st period:____ Frequency of periods:_____ Length of each: _____
Have you ever had an abnormal PAP test? Y N Any concerns about menopause/periods? Y N _____