

# Patient - Complete This Side Only

## Patient History/Data Form

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Race: \_\_\_\_\_

**Review of systems:**

*Circle if you have problems with:  
(no circle indicates "No Problem")*

- Constitutional
  - Weight - Loss / Gain
  - Fever
- Eyes
- Ears, Nose, Mouth, Throat
- Cardiovascular
  - Heart
  - Blood Pressure
- Respiratory
  - Breathing
  - Shortness of Breath
- Gastrointestinal
  - Stomach
  - Constipation
  - Diarrhea
- Genitourinary
  - Female Organs, Urinary or Bladder Incontinence
- Vaginal Discharge
- Muscular Skeletal
  - Back
  - Joints
  - Hands
  - Feet
- Integumentary
  - Skin
  - Breast
- Neurological
  - Balance
  - Confusion
- Psychiatric
  - Anxiety
  - Depression
- Endocrine
  - Thyroid
  - Blood Sugar - Low / High
- Hematologic
  - Anemia
  - Swelling
- Sexually Transmitted Diseases
  - Genital Warts/HPV
  - Herpes
  - Chlamydia
  - Gonorrhea
  - HIV
  - Hep B & C
- All Others Negative \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_
- Social History
  - Drink Alcohol  Yes  No
  - Amount \_\_\_\_\_
  - Substance Abuse  Yes  No
  - Amount \_\_\_\_\_
  - Drink Caffeine  Yes  No
  - Amount \_\_\_\_\_
  - Smoke  Yes  No
  - Packs per day \_\_\_\_\_
  - Exercise  Yes  No
  - Amount \_\_\_\_\_
  - Calcium Intake  Yes  No
  - Amount \_\_\_\_\_

What is your major concern today? \_\_\_\_\_

Allergy \_\_\_\_\_

**Past History:**

Date last period began: \_\_\_\_\_ Date the previous period began: \_\_\_\_\_

Do you consider your period normal? \_\_\_\_\_ Age started: \_\_\_\_\_

How often do your periods occur(days from beginning of one to beginning of next?) \_\_\_\_\_

Duration (days from start to stop): \_\_\_\_\_

Usual flow: Scant \_\_\_\_\_ / Moderate \_\_\_\_\_ / Severe \_\_\_\_\_

Pain: None \_\_\_\_\_ / Mild \_\_\_\_\_ / Moderate \_\_\_\_\_ / Severe \_\_\_\_\_

Spotting or bleeding between periods: No \_\_\_\_\_ / Yes \_\_\_\_\_

Date of last Mammogram?: \_\_\_\_\_ Abnormal? \_\_\_\_\_

Last PAP Smear: \_\_\_\_\_

Any previous abnormal PAP's? \_\_\_\_\_ If yes, when? \_\_\_\_\_

Type of treatment? \_\_\_\_\_

Bone Density Scan? Yes \_\_\_\_\_ / No \_\_\_\_\_ Results: \_\_\_\_\_

Year	Operation / Surgeries	Year	Hospitalizations (excl. Ob & Surg.)

**PREGNANCIES:**

Year	Sex	Weight, complications (delivery, miscarriage, abortion, C-Sec.)
1.		
2.		
3.		
4.		

**SEXUAL HISTORY:**

Age at first sexual intercourse? \_\_\_\_\_

Has your sexual partner had sex with other people in the last year? \_\_\_\_\_

Is your partner bisexual, an IV drug user, a hemophiliac, or a blood transfusion recipient? \_\_\_\_\_

Have you had sex with more than one person in the last year? \_\_\_\_\_

Do you have concerns about your sex life? Yes \_\_\_\_\_ / No \_\_\_\_\_

**FAMILY HISTORY:**

Has any blood relative had...	Yes	No	Whom	Age
Cancer of Breast				
Cancer of Female Organs				
Diabetes				
High Blood Pressure				
Stroke				
Bleeding Disorders				
Blood clot in legs/lungs				
Heart Attack				
Other Family Diseases				
Birth Defects				
Osteoporosis				
Colon Cancer				
High Cholesterol				

Patient data sheet reviewed \_\_\_\_\_

Marital Status  
M    S    D    W

Positive responses dictated, all others reviewed and negative.