Name: _____ DOB: _____ Date: _____ ☐ Single ☐ Married

Who is your Family Doctor?: _____ Phys. Tele #_____ ☐ Widowed ☐ Divorced

Reason for today's visit? _____ Allergies:_____

List medications, herbals or vitamins you take

SINCE YOUR LAST VISIT HAVE YOU:		
Discovered you are allergic to anything new?	☐ No	☐ Yes What?: Reaction?
Had any changes to your health?	☐ No	☐ Yes What?
Had anyone in your immediate family diagnosed with a serious illness?	☐ No	☐ Yes Who? What Illness?
Had a death in your immediate family?	☐ No	☐ Yes Explain
Received any immunizations?	☐ No	☐ Yes Type?
Had any pregnancies, miscarriages or abortions?	☐ No	☐ Yes # of Peg. Miscar. Abortions Live Children:
Had any changes in your period?	☐ No	☐ Yes
Had any abnormal bleeding?	☐ No	☐ Yes
Had any pelvic pain? Painful Intercourse?	☐ No	☐ Yes
Had any signs of menopause?	☐ No	☐ Yes
Regularly done self-breast exams?	☐ Yes	☐ No
Are you currently sexually active?	☐ No	☐ Yes
Changed sexual partners?	☐ No	☐ Yes
Had multiple sexual partners?	☐ No	☐ Yes Circle Male/Female/Both Total Number
Been treated for sexually transmitted disease(STD)?	☐ No	☐ Yes
Do you wish to be tested for any STDs?	☐ No	☐ Yes
Do you wish to be tested for HIV/AIDS?	☐ No	☐ Yes
Been Hospitalized?	☐ Yes	☐ No Date:
Had a PAP Smear?	☐ Yes	☐ No Date:
Had a mammogram?	☐ Yes	☐ No Date:
Had a Dexascan or heel scan?	☐ Yes	☐ No Date:
Had a sigmoid/colonoscopy?	☐ Yes	☐ No Date:
Had a stool check for blood?	☐ Yes	☐ No Date:
Had a cholesterol check?	☐ Yes	☐ No Date:
Had a complete physical?	☐ Yes	☐ No Date:
PERSONAL HABITS Do you		
Use tobacco products?	☐ No	☐ Yes How much? How often?
Drink alcohol?	☐ No	☐ Yes How often? What kind?
Use illegal drugs?	☐ No	☐ Yes How often? What kind?
Exercise Regularly?	☐ Yes	☐ No How often? What type?
Take Calcium or Calcium Supplement regularly	☐ Yes	☐ No How much? How often?

REVIEW OF SYSTEMS - Please answer "Yes" or "No" to the following questions.

Constitutional			**Genitourinary**			**Respiratory**			**Neurological**		
Fever/Chills	Yes	No	Urine leaking	Yes	No	Wheezing	Yes	No	Seizures/Fainting	Yes	No
Weight Change	Yes	No	Painful urination	Yes	No	Frequent cough	Yes	No	Dizzy spells	Yes	No
Fatigue	Yes	No	Urinary frequency	Yes	No	Shortness of Breath	Yes	No	Numbness/tingling	Yes	No
Other			Vaginal discharge	Yes	No	Other:			Other:		
Endocrine (Lymph System)			**Gastrointestinal**			**Cardiovascular**			**Integumentary (Skin)**		
Excess Thirst/Diabetes	Yes	No	Abdominal pain	Yes	No	Chest pains	Yes	No	Skin Rash	Yes	No
Too hot/cold	Yes	No	Nausea/vomiting	Yes	No	Palpitations	Yes	No	Dark Moles	Yes	No
Thyroid Problems	Yes	No	Indigestion/heartburn	Yes	No	Edema	Yes	No	Persistent itch	Yes	No
Other:			Constipation/Diarrhea	Yes	No	Other:			Other:		
Musculoskeletal			**Breast**			**Psychologic**					
Joint pain	Yes	No	Pain	Yes	No	Are you satisfied with your life?	Yes	No			
Neck/back pain	Yes	No	Discharge	Yes	No	Feeling Depressed?	Yes	No			
Muscle Weakness	Yes	No	Masses	Yes	No	Have you considered suicide?	Yes	No			
Other:			Other:			Have you been abused?	Yes	No			

FAMILY HISTORY:

Mother: ☐ Living ☐ Deceased - Cause _____ Age: __ Father: ☐ Living ☐ Deceased - Cause _____ Age: __

Siblings: Number Living: __ Number Deceased: __ Cause(s)/Age(s): _____

Children: Number Living: __ Number Deceased: __ Cause(s)/Age(s): _____

Do you have a family history of? (If Yes, indicate whom and age at diagnosis)

☐ Diabetes _____ ☐ Heart Disease _____ ☐ High Cholesterol _____

☐ Hypertension _____ ☐ Blood Clots/Pulmonary Embolism: _____ ☐ Osteoporosis _____

☐ Cancer _____ ☐ Breast ☐ Ovarian ☐ Colon ☐ Uterine ☐ Other Cancer _____

☐ Other Illness

PHYSICAL EXAMINATION

Patient Name: _____ Date: _____ DOB: _____
Last Menstrual Period: _____ Contraception: _____ Gravida: ____ Para: ____
Chief Complaint:

B/P:	Weight:	Height:	Age:	

GENERAL	☐ Nml	
NECK/THYROID	☐ Nml	
HEART(Periph Vacs)	☐ Nml	☐ Murmers ☐ Gallops ☐ Rubs
LUNGS(Resp. effort)	☐ Nml	
LYMPH NODES	☐ Nml	☐ Neck NML ☐ Axilla NML ☐ Groin NML
ABDOMEN	☐ Nml	☐ Liver ☐ Spleen
CNS	☐ Nml	Oriented to ☐ Self ☐ Time ☐ Space
EXTREMITIES	☐ Nml	
BREASTS	☐ Nml	☐ Skin Retraction ☐ Lymph Node Enlargement ☐ Asymetry ☐ Nipple Discharge ☐ Dominant Masses ☐ Fibrocystic Changes
SKIN(Insp./Palpate)	☐ Nml	
PELVIC EXAM		
EGBUS	☐ Nml	
URETHRA	☐ Nml	
VULVA	☐ Nml	
VAGINA	☐ Nml	
CERVIX	☐ Nml	
UTERUS	☐ Nml	
ADNEXA:	☐ Nml	☐ Palpable ☐ Tender
Rectal	☐ Nml	
CVA	☐ Nml	☐ Not Done

Specimen Collected: ☐ PAP ☐ GC/Chl ☐ Preg. Test ☐ Hemocult ☐ Wet Mount

ADDITIONAL FINDINGS:

IMP:

PLAN:
☐ Mammo
☐ Dexa

Counseled:
☐ NOT Applicable ☐ Breast self exam ☐ Condom use ☐ Contraception
☐ Hormone replacement ☐ Calcium/osteoporosis ☐ Heart disease
☐ Diet/exercise/weight control ☐ Preconception Folic Acid ☐ Controversy re: Breast Cancer & HRT
_____ Minutes Counseled **Return Visit: ____ Days/Weeks/Months/Year**

Physician Signature: _____ Date: _____