Name_____ **Date of Birth**_____/_____/_____ **Age** ____ **GW#** _____

Age of first menstrual period _____ **No. of Pregnancies** _____ **No. of Deliveries** _____ **No. of Living** _____

Start Date of Last Menstrual Period_____ **Birth Control Method** _____

Change in Prescriptions Yes /No **Change in Medical History** Yes / No **Surgeries since Last Visit** Yes / No

If yes, to any of the above questions please indicate change on your patient summary page given to you upon arrival.

Reason for today's Visit: **Annual** **or** **Problem / Describe** _____ **(Circle One)**

Date of Last:	**(Circle Answers)**
Mammogram _____	**Normal / Abnormal**
Bone Density_____	**Normal / Abnormal**
Cholesterol _____	**Normal / Abnormal**
Colonoscopy _____	**Normal / Abnormal**
Flu Vaccine _____	
Pneumonia Vaccine _____	
HPV Vaccine _____	
(Circle No. of three shot series completed 1 2 3)	

	(Circle Answers)
Sexually Active	**Yes No**
Sexual Partner	**Male Female**
New Partner in past year	**Yes No**
Smoker	**Yes Never Former**
Alcohol Use	**Yes None Former**
Drug Use	**Yes Never Former**
Relationship Abuse	**Current Hx of N/A**
Episode of Falling in Past Yr. No. of episode(s) _____	**N/A**
Do you use Medical Device to prevent falls: _____	**Type N/A**

REVIEW OF SYSTEMS **(☒ Condition you are now experiencing)**

CONSTITUTIONAL		**GASTROINTESTINAL**		**NEUROLOGICAL**	
	Fatigue		Nausea		Numbness / Tingling
	Fever		Vomiting		Difficulty Concentrating
	Chills		Diarrhea		Seizures
	Night Sweats		Abdominal Pain		Muscular Weakness
	Loss of Appetite		Hemorrhoids		Memory Difficulties
	Weight Loss		Reflux/Indigestion		Speech Difficulties
	Weight Gain		Change in Bowel Habits		
			Constipation		
HEENT		**GENITOURINARY**		**MUSCULOSKELETAL**	
	Headaches		Frequency of Urination		Joint Pain
	Thyroid Lump		Incontinence / Loss of		Recent Fractures
	Vision Changes		Urgency of Urination		
			Pain with Urination		
BREASTS			Night time Urination	**ENDOCRINE**	
	Lumps		Blood in Urine /		Abnormal Hair Growth
	Tenderness / Pain		Decrease Sex Drive		Hair Loss
	Nipple Discharge/Secretions		Painful Intercourse		Heat Intolerance
	Rash		Possible Pregnancy		Cold Intolerance
			Significant PMS		
CARDIOVASCULAR			Irregular Bleeding	**PSYCHIATRIC**	
	Chest Pain		Genital Skin Changes		Anxiety
	Irregular Heart Beat		Pelvic Pain		Difficulty Sleeping
	Varicose Veins **(New or Changed)**		Vaginal Discharge		Suicidal Thoughts
	Leg Swelling		Vaginal Odor		Homicidal Thoughts
			Possible STD Exposure		
RESPIRATORY		**SKIN / INTEGUMENT**		**HEMATOLOGIC / LYMPHATIC**	
	Shortness of Breath		Rash		Bruises: Frequent or Easily
	Chronic Cough		New Skin Lesions		Enlarged Lymph Nodes
	Wheezing		Changes to Existing		
			Acne		

What other additional issues would you like to discuss? _____

OFFICE USE: WT: _____ HT: ___/___ BP: _____/_____ ☐ Pregnancy Test done ____ Positive ____ Negative

☐ UA Leuk. ____ Nitr._____ Urobil._____ Prot._____PH._____ Bld.____ SpGr._____Ket._____Bilir._____Gluc._____