

The information on this form is intended to help the physician with your diagnosis and treatment. Please complete both pages of the form as fully as possible.

Name _____ Date _____ Best way to reach you: _____

Age _____ Birth Date _____ Marital Status: S M Sep W D Current Job _____

Primary Care Physician: _____ When was your last visit in that office? _____
Who lives with you at this time? _____ Who referred you to this medical practice? _____

FAMILY HISTORY:

No Yes Are you adopted?

Has anyone in your family had the following: Include Mother (M), Father (F), Brother (B), Sister (S) Grandfather (MGF or PGF - Maternal or Paternal), Grandmother (MGM or MGF - Maternal or Paternal)

Table with 3 columns: No Yes Who, No Yes Who, No Yes Who. Rows include Diabetes, Heart disease, Lung disease, Depression, High blood pressure, Stroke, High cholesterol, Thyroid disease, Osteoporosis, Sickle-Cell disease, Arthritis, Other hereditary diseases, Breast cancer, Ovarian cancer, Uterine cancer, Cervical cancer, Colon cancer, Other cancers.

MEDICAL HISTORY/REVIEW OF SYSTEMS:

No Yes Now

Do you have, or have you ever had, any of the following:

No Yes Now

No Yes Now

- Weight gain/loss >10 lbs
Marked fatigue
Hearing loss
Sinus problems
Heart disease
Lung disease
Chest pain
Palpitations
High blood pressure
Varicose veins
Anemia
Cancer, Type _____

- Breast disease
Diabetes
Thyroid problem
Depression/anxiety
Numbness or tingling of extremities
Epilepsy/seizures
Stroke
Headaches
Difficulty swallowing
Bleeding disorders
Osteoporosis

- Kidney problem
Bladder infection
Stomach/bowel problem
Liver disease
Shortness of breath
Arthritis
Toxic work exposure
Skin problems
Asthma
Blood clots
Other illness (list type) _____

MEDICATIONS

Please list all medications you are using by name and dosage (include vitamins and herbs)

Birth control _____

ALLERGIES

Are you allergic to (circle): Latex Iodine/Shellfish
Allergies to medications: Please list drug and reaction:

SURGICAL/HOSPITALIZATION HISTORY

Date

Type

Please list the date and type of surgery or reason for hospitalization:

Date

Type

Name _____ DOB _____

PREGNANCY HISTORY

Table with 4 columns: Date of Pregnancies (date of delivery, loss, or termination), Type of Delivery (vaginal/c-section/loss), Complications, Sex. Includes 4 rows of blank lines for data entry.

GYN/MENSTRUAL HISTORY

Age period started _____ LMP _____
Are your periods coming every month? _____
How many days of bleeding? 2 3 4 5 6 7 8 more?
How many changes a day when heavy? 2 3 4 5 6 7 8 more?
Do you see clots? _____ How bad is the pain? _____

No Yes Are you sexually active? Your partner is: Male Female

Do you have now, or have you ever had problems with the following:

- No Yes Now
Severe cramps with your period
Bleeding between periods
Vaginal discharge/infection
STD (sexually transmitted disease):
syphilis gonorrhea trichomonas
chlamydia herpes genital warts HIV
Abnormal Pap smears
Abnormalities of the uterus
Tumors/cysts of ovaries
Infertility/Endometriosis
Sexual difficulty
Pain/bleeding with intercourse
Bothersome loss of urine

WELLNESS/SCREENING

Date of last test/immunization:
Pap smear
Mammogram
Bone density
Cholesterol
Colonoscopy or Sigmoidoscopy
Fecal Occult Blood cards
Tetanus shot
Pneumonia Vaccine

No Yes Do you have a health care proxy?
No Yes Do you perform self breast exams monthly?
No Yes Do you exercise? Type & frequency: _____

No Yes Do you get enough calcium (1200 mg)?
No Yes Do you always wear your seat belt?
No Yes Are you current with dental care?
No Yes Are you on any particular diet?
No Yes 3 Gardasil Vaccinations completed (if < age 27?)

SOCIAL HISTORY

Circle the highest year of school completed: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 >17 Degree _____

Occupation _____ Employer _____

No Yes Caffeine: Average amount /day _____
No Yes Tobacco: If Yes, _____ packs/day for how many years _____
No Yes Street drugs: what? _____
No Yes Alcohol: # drinks per day (beer, wine, liquor) _____
No Yes History of physical or sexual abuse?

TODAY'S VISIT

What concerns or problems would you like to discuss today?

Are you interested in?:
No Yes HIV (AIDS) testing?
No Yes Other STD testing?
No Yes Chaperone with exam

Patient's Signature _____ Date _____

OFFICE USE ONLY:

I have reviewed the above and personally discussed this with the patient: Oliver Kreitmann, MD _____ Date _____