Valley Center for Women's Health, P.A.

Preventive Health Assessment

☐ Susan Flanzman, MD ☐ Jennifer Reich, MD

Patient Name:_____ **Date:** _____

DOB:_____ **Age:** _____

History of Present Illness:

_____

_____

_____

_____

_____

_____

History updated: ☐ see H.I.S. **Medications updated:** ☐ see med list **Preventive Med screening**: ☐ see H.M.S. **Allergies** _____

Exam:

Vital Signs Ht. _____ Wt. _____ BP _____ Pulse _____ Temp _____ Respiration _____ Urine: _____

General appearance	normal ___	abnl ___	
Eyes: Conjunctivae	normal ___	abnl ___	
Pupils	normal ___	abnl ___	
HENT: Maxiallary/facial tenderness	normal ___	abnl ___	
Canal/TM	normal ___	abnl ___	
Hearing	normal ___	abnl ___	
Nasal mucosa/turbinates	normal ___	abnl ___	
Lips/teeth/gums	normal ___	abnl ___	
Oropharynx	normal ___	abnl ___	
Neck: Appearance /Masses	normal ___	abnl ___	
Thyroid	normal ___	abnl ___	
Lymphatic: Neck	normal ___	abnl ___	
Supraclavicular	normal ___	abnl ___	
Other:	normal ___	abnl ___	
Resp: Respiratory effort	normal ___	abnl ___	
Auscultation of lungs	normal ___	abnl ___	
Cardio: Auscultation of heart	normal ___	abnl ___	
Carotid arteries	normal ___	abnl ___	
Other bruits:	normal ___	abnl ___	
Skin	normal ___	abnl ___	
Psych: Mood/Affect	normal ___	abnl ___	
Comments:			

GI: Abdomen	normal ___	abnl ___	
Liver/Spleen	normal ___	abnl ___	
Rectal: tone/masses	normal ___	abnl ___	
Hemeoccult test	normal ___	abnl ___	
GYN/GU: Breast	normal ___	abnl ___	
External /Vaginal walls	normal ___	abnl ___	
Cervix	normal ___	abnl ___	
Uterus	normal ___	abnl ___	
Adnexa	normal ___	abnl ___	
Testicular exam	normal ___	abnl ___	
Prostate	normal ___	abnl ___	
Neuro: Orientation	normal ___	abnl ___	
Cranial nerves	normal ___	abnl ___	
Tendon reflexes	normal ___	abnl ___	
Sensation	normal ___	abnl ___	
MSK: Gait	normal ___	abnl ___	
ROM	normal ___	abnl ___	
Strength/tone	normal ___	abnl ___	
Stability/other	normal ___	abnl ___	
Extrem: Edema	normal ___	abnl ___	
Peripheral pulses	normal ___	abnl ___	

Impression/Plan:

Health Maintenance: Counseled in detail on the importance of calcium intake, appropriate diet, exercise, use of sunscreen, seat belts, safe sex, and the complications of tobacco and excessive ETOH use.

_____

_____

_____

_____

Tests to f/u:

Return _____ days _____ weeks _____ months _____ years _____PRN

MD Signature: _____ Date: _____

Valley Center for Women's Health, P.A.
History Intake Form

Patient Name	DOB	Today's Date
		☐ New Patient
Phone Number	Age	☐ Established Patient

Reason for today's visit? _____

_____

Are there any questions you would like to discuss? ☐ Yes ☐ No

_____

_____

Past History:

Do you have any **medical problems**? ❑ Yes ❑ No
Please list:

Have you had any type of **surgery**? ❑ Yes ❑ No
Please list:

Are you on any **medications**? ❑ Yes ❑ No
Please list/dosages:

Do you have any **allergies**? ❑ Yes ❑ No
Please list:

Do you have a **health care proxy**? ❑ Yes ❑ No
Name/phone number:

Family History:

Diabetes:	❑ Yes ❑ No
Heart Disease:	❑ Yes ❑ No
Heart Attacks:	❑ Yes ❑ No
Stroke:	❑ Yes ❑ No
Urinary Stones:	❑ Yes ❑ No
Kidney Problems:	❑ Yes ❑ No
Kidney Cancer:	❑ Yes ❑ No
Prostate Cancer:	❑ Yes ❑ No
Breast Cancer:	❑ Yes ❑ No
Ovarian Cancer	❑ Yes ❑ No

Other:

Social History:

Currently Use Tobacco?: ❑ Yes ❑ No
_____ Cigarettes/Packs Per Day
Have You Ever Smoked? ❑ Yes ❑ No
_____ Average Cigarettes/Packs Per Day
_____ Number of years
Alcohol/Drug Use: ❑ Yes ❑ No
Please list:

Occupation:

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History Intake Form

Immunizations/Approximate Dates

Influenza	MMR
Pneumovac	Varicella(Chicken Pox)
Tetnus	Hepatitis B
Others	

Review of Systems:

1. **Constitutional**
- Weight loss? ❑ Yes ❑ No
- Weight gain? ❑ Yes ❑ No
- Fever & Chills? ❑ Yes ❑ No

2. **Eyes**
- Visual changes? ❑ Yes ❑ No
- Glasses/contact lenses? ❑ Yes ❑ No

No

3. **ENT/Mouth**
- Headaches? ❑ Yes ❑ No
- Cold sores? ❑ Yes ❑ No
- Allergies/hay fever? ❑ Yes ❑ No

4. **Cardiovascular**
- Chest pains? ❑ Yes ❑ No
- Palpitations? ❑ Yes ❑ No
- Swelling/Edema? ❑ Yes ❑ No

5**. Respiratory**
- Shortness of breath? ❑ Yes ❑ No
- Coughing? ❑ Yes ❑ No
- Wheezing? ❑ Yes ❑ No

6. **Gastrointestinal**
- Diarrhea? ❑ Yes ❑ No
- Nausea/Vomiting? ❑ Yes ❑ No
- Constipation? ❑ Yes ❑ No

7. **Genitourinary**
- Pain with urination? ❑ Yes ❑ No
- Frequent urination? ❑ Yes ❑ No
- Incontinence? ❑ Yes ❑ No
- Sexually Transmitted Disease? ❑ Yes ❑ No

8. **Sexual Function**
- Decreased sexual interest/drive/libido? ❑ Yes ❑ No
- Decreased lubrication/vaginal dryness? ❑ Yes ❑ No
- Decreased arousal/excitement/erectile dysfunction? ❑ Yes ❑
- Orgasm change/premature ejaculation? ❑ Yes ❑ No
- Pain during sex ? ❑ Yes ❑ No

8. **Skin/Breast**
- Rashes? ❑ Yes ❑ No
- Breast pain? ❑ Yes ❑ No
- Nipple discharge? ❑ Yes ❑ No
- Lumps in breast? ❑ Yes ❑ No

9**. Endocrine**
- Sugar problems? ❑ Yes ❑ No
- Thyroid problems? ❑ Yes ❑ No
- Hot flashes? ❑ Yes ❑ No

10**. Psychiatric**
- Depression? ❑ Yes ❑ No
- Anxiety? ❑ Yes ❑ No
- Mood Changes? ❑ Yes ❑ No

*X*_____ _____
Patient Signature Date

*X*_____ _____
MD Signature Date

To be completed by the physician

Date reviewed: _____ Any Changes? ❑ Yes ❑ No
_____
MD Signature

Date reviewed: _____ Any Changes? ❑ Yes ❑ No
_____
MD Signature

Date reviewed: _____ Any Changes? ❑ Yes ❑ No
_____
MD Signature