Name: ________________________________ **DOB:** __________ **Date:** ______________________

1) **If you are a returning patient, please review your printed medical history at your appointment and make changes if needed.**
2) **Please circle ANY symptoms that are present:**

Appetite changes	Weight Changes	Fever	Chills
Malaise	Fatigue	Hives	Itching
Rash	Seasonal Allergies	Muscle Pain	Joint Pain
Abnormal Mole	Skin Cancer ______________________		
Shortness of Breath	Cough	Wheezing	
Chest Pain	Loss of consciousness	Swelling in Ankles	
Nausea	Vomiting	Abdominal Pain	Bowel Changes
Diarrhea	Constipation	Heartburn	
Painful Urination	Blood in Urine	Night time Urination	Urinary Urgency
Urinary Frequency	Inability to Urinate	Urinary Incontinence	
Cold Intolerance	Excessive Thirst	Heat Intolerance	
Breast Lump	Breast Pain	Nipple Discharge	
Anxiety	Depression		
Visual Impairment	Blurred Vision	Ringing in Ears	Double Vision
Nosebleed	Hearing Loss	History of Abnormal Pap Smears	
Heavy Menstrual Periods	Pain with Intercourse	History of Sexually Transmitted Disease	
Bleeding between Periods	Abnormal Vaginal Discharge	PMS Symptoms	Hot Flashes/Sweats
Painful Periods	Vaginal or Vulvar Itching	Bleeding After Intercourse	

3) **If you are having menstrual periods, please answer the following:**
   Last Menstrual period: ________________________ Birth Control Method: ___________________
   How often are your periods? ____
   How long do your periods last? ____
   How often do you change your sanitary product? __________________________
   Do you have cramps? **Y** **N** Are they mild/moderate/severe? ______________________________
   Do you take medication for your cramps? **Y** **N** ____
4) **Please circle if you have ever had a history of sexually transmitted disease:**

Chlamydia	**Gonorrhea**	**Herpes**	**HPV**
Syphillis	**Hepatitis**	**Trichomonas**	**HIV**

5) **If this is an annual exam, please provide most recent dates and results (please circle) for the following tests: DATE: RESULT: COMMENTS:**

Test / DATE	RESULT	COMMENTS
Pap Smear	Never Normal Abnormal	
Bone Density	Never Normal Abnormal	Osteopenia Osteoporosis
Mammogram	Never Normal Abnormal	
Cholesterol	Never Normal Abnormal	
Colonoscopy	Never Normal Abnormal	

Office Use Only:

HT: WT: BP: LMP: T:

Smoking/Alcohol Questionnaire

Do you smoke? Yes No Are you a former smoker? Yes No

1) **If you are a current smoker:**
   a) **How often do you smoke cigarettes?**
   Every day Some days, but not every day
   b) **How many cigarettes a day do you smoke?**
   5 or less 6-10 11-20 21-30 31 or more
   c) **How soon after you wake up do you have your first cigarette?**
   Within 5 minutes 6-30 mins 31-60 mins after 60 mins
   d) **Are you interested in quitting?**
   Ready to quit Thinking about quitting Not ready to quit

2) **If you are a former smoker, how long has it been since you last smoked?**
   Less than 1 month 1-3 mos 3-6 mos 6-12 mos
   1-5 years 5-10 years greater than 10 years

Did you have a drink containing alcohol within the past year? Yes No

3) **If you have had a drink containing alcohol in the past year:**
   a) **How often did you have a drink containing alcohol in the past year?**
   Monthly or less 2-4 times per month
   2-3 times per week 4 or more times per week
   b) **How many drinks did you have on a typical day when you were drinking in the past year?**
   1 or 2 3 or 4 5 or 6 7 to 9 10 or more
   c) **How often did you have six or more drinks on one occasion in the past year?**
   Never Less than monthly Monthly Weekly Daily or Almost Daily

(The above questions are required by the federal government)