

NAME: _____ DOB: _____ DATE: _____

CURRENT PROBLEMS

Please check all that apply:		
General	Cardiovascular	Skin
Fever	Chest pain	Rash
Chills	Cardiac palpitations	Itching
Weight loss	Irregular heartbeats	New skin lesions
Weight gain	Swelling in legs	New lumps/lesions
Decreased energy	Varicosities	Excessive body hair
Loss of appetite		Gastrointestinal
Hot flashes		Musculoskeletal
Eyes	Diarrhea	Joint pain
Visual disturbances	Constipation	Back pain
Dry eyes	Heartburn	Muscle weakness
Glaucoma	Vomiting blood	Muscle cramps
Ears, Nose, Throat	Nausea/vomiting	Endocrine
Sore throat	Blood in stools	Excessive thirst
Sinus problems	Loss of appetite	Heat intolerance
Frequent colds	Genitourinary	Difficulty staying warm
Headaches	Leaking urine	Hair loss
Breasts	Pain with urination	Emotional
Lumps	Frequent urination	Depression
Tenderness/pain	Vaginal discharge	Anxiety
Swelling	Vaginal dryness	Emotional changes
Nipple discharge	Abnormal pap smear	Difficulty sleeping
Respiratory	Uterine tumor	Mood swings
Shortness of breath	Unusual bleeding	Hematologic
Wheezing	Ovary problems	Easy bruising
Chronic Cough	Painful intercourse	Easy bleeding
	Decreased libido	

Medical History (please check all that apply and tell us who)

Personal History	Family History	Who
Diabetes	Diabetes	
Heart disease	Heart disease	
Stroke	Stroke	
DVT	DVT	
High blood pressure	High blood pressure	
High cholesterol	High cholesterol	
Bleeding tendencies	Bleeding tendencies	
Sickle cell trait	Sickle cell trait	
Osteoporosis	Osteoporosis	
Asthma	Asthma	
Thyroid disease	Thyroid disease	
Any hereditary disease	Any hereditary disease	
Birth defects	Birth defects	
Colon cancer	Colon cancer	
Endometrial cancer	Endometrial cancer	
Breast cancer	Breast cancer	
Cervical Cancer	Cervical Cancer	
Ovarian Cancer	Ovarian Cancer	

Please complete other side.

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