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FEMALE PATIENT WORKSHEET FOR PERIODIC PHYSICAL: Please fill these forms in as best you can prior to coming in for your physical. Doing so will make for more efficient use of your time in the office, as well as helping ensure that you don't miss giving, or I miss requesting, information that should be considered. Please continue on another sheet of paper if more room is needed.

IDENTIFYING DATA:

Name_____ ******12 Hour Fast Prior to Appointment ******

Birth date_____ ****** Drink Water ******

Date your physical is scheduled_____

CURRENT HEALTH PROBLEMS AND SPECIAL CONCERNS: Please list any symptoms or concerns which you feel may be a health problem. Where you can, list the symptom and:

(a) when it started
(b) whether steady or intermittent
(c) whether has any relation to the time of day, meals, or any other activity or event
(d) what makes it better
(e) what makes it worse
(f) what other symptoms occur with it
(g) what it feels like to you
(h) what you are most concerned about regarding it

Symptom	Description

PAST HISTORY:

- Please list all events which have ever involved hospital admissions or major illnesses, injuries, or surgery:

Hospital Admissions, Major Illnesses, Injuries, or Surgeries

- Please list occasions where you have been treated for high blood pressure. Vein clots, passing out, asthma, heart problems, kidney problems, hepatitis, ulcers, bleeding problems, or significantly abnormal tests:

Disease	No	Yes	Where and When Treated
High Blood Pressure			
Vein Clots			
Passing Out			
Asthma			
Heart Problems			
Kidney Problems			
Hepatitis			
Ulcers			
Bleeding Problems			
Significantly Abnormal Tests			

MEDICATION HISTORY:
Please list: medication, dose, when taken, and year started for all regularly taken medications including over the counter medications and vitamins:

Medication	Dosage	When Taken	Year Started

ALLERGIES: Please list medications, and reaction, for medications to which you have an allergy or to which you have undesirable side effects:

Medication	Reaction	Date

FAMILY HISTORY: Please list below the following information.

- Number of brothers & sisters: _____ _____ Number of Aunts & Uncles:_____ _____
- Age at death & cause of death for parents, grandparents, and brothers or sisters:

Relative	Age at Death	Cause of Death	Relative	Age at Death	Cause of Death
Father			Brother		
Mother			Brother		
MGM			Brother		
MGF			Sister		
PGM			Sister		
PGF			Sister		

MGM = Maternal Grandmother MGF = Maternal Grandfather
PGM = Paternal Grandmother PGF = Paternal Grandfather

- Family members (parents, grandparents, uncles, aunts, brothers, or sisters), & condition they had, for any of the following or for other conditions seeming to run in the family:

Disease	No	Yes	If Yes, Which Family Members
Heart Attacks			
Stroke			
Diabetes			
Cholesterol Problems			
High Blood Pressure			
Asthma			
Bleeding Disorders			
Kidney Disease			
Epilepsy			
Migraine			
Neuromuscular Disease			
Mental Disease			
Osteoporosis			
Cancer			
Blood Diseases			
Genetic or Hereditary			
Other Diseases			

SOCIAL HISTORY: Please List:

Birthplace:	Nationality:	Religion:
Place of Work & Job Description:		
Others Living at Home:		
Major Interests:		
Any Foreign Residence:		
Amount of Daily Alcohol:	Amount Daily Tobacco:	Amount Daily Caffeine:
Other Substance Usage:		
Meals/Day:	# Vegetables/Day:	
# Fruits/Day:	# Of Between Meal Items/Day:	
Times/Week of Exercise:	# Minutes/Exercise:	
Exercise Activities:		

HEALTH MAINTENANCE: Please list date (& any unfavorable outcomes) for last:

General Physical	EKG	
General Blood Screens	Other Routine Tests or Procedures	
DT(tetanus shot)	Measles Shot	Pneumonia Shot
Flu shot	Pap Smear	Mammogram
Sigmoidoscopy	Colonoscopy	

ADVANCE DIRECTIVES:

- Have you made a Living Will or Medical Power of Attorney?
- If not, do you have any express wishes on life support if you should develop a catastrophic medical condition?

Review of Systems

SYSTEM REVIEW: Please place a check mark in the yes column for any of the following conditions or situations where you have experienced symptoms or occurrences, or where you have questions. Explain all "yes" symptoms at the end.

GENERAL	Yes	No	
			Have you had unexplained or significant weight change?
			Have you had fever, chills, night sweats or temperature intolerance?
			Have you had unexplained pain, bleeding, weakness or tiredness?
			Have you had any sort of spells or attacks?
DERMATOLOGIC			Have you had any lumps or skin lesions that are changing or are of concern to you?
			Have you had unusual or troublesome itching, rashes, or pigmentation changes?
HEENT			Have you had any recent change in vision or visual symptoms?
			Do you have any trouble with hearing, ringing, or pain in the ears?
			Any trouble chewing or swallowing?
			Any mouth sores or lesions?
RESPIRATORY			Have you had a cough which is changing or is productive or colored material or blood?
			Have you had wheezing or other breathing difficulties?
CARDIOVASCULAR			Have you had any pain or distress that you feel may be from your heart?
			Do you get unusual shortness of breath or fatigue with ordinary activities, such that you need to stop for rest or avoid them?
			Do you have problems with swelling or palpitations?
			Does anything else lead you to feel that you have heart or circulation problems?
GASTROINTESTINAL			Have you had any unusual or troublesome problems with swallowing, digestion, appetite loss, or abdominal pain or distress?
			Have you had problems or changes with bowel habits or bowel movements?
			Have you noticed any blood or black tarry bowel movements?

	Yes	No	
UROLOGIC			Have you had any problems with starting, stopping, or frequency of urination or any pain or distress with urination?
			Have you had any blood in the urine or any other abnormalities or significant changes in urine or urination?
GENITAL			Have you had problems with pain, irregular or heavy bleeding, or other problems with menstrual periods?
			Have you had lumps or other breast problems?
			Have you had problems with premenstrual tension?
			Have you had hot flashes, pelvic pain, or any sexual problems?
			Had you had more than 1 sexual partner in the last year?
MUSCULOSKELETAL			Have you had unusual or troublesome joint swelling or stiffness?
			Have you had to limit activities due to muscle, joint, or bone pain?
NEUROLOGIC			Have you had unusual or severe headaches?
			Have you had any problems with memory or concentration?
			Have you had problems with balance or coordination, or with doing activities with which you normally do not have problems?
			Have you had problems with numbness, vision, taste, smell, or speech?
BEHAVIORAL			Do you feel, or have you been told, that you need to cut down on alcohol consumption?
			Are there other habits or problems that you feel, or that you have been told, that you need to better control?
			Do you feel your life situation is hopeless?
			Are you having unusual or overwhelming stress or depression?
			Have you stopped doing activities because of fears, panic, or feelings of inadequacy, hopelessness, or general disinterest?
			Have you had sleep problems?
			Have you had any personality changes?
			Have you had other problems causing you to feel you might benefit by some type of psychiatric help?