

Name: _____

Date: _____

1.

Your appointment today is scheduled for an annual. If your priority is not preventative care, but rather to follow-up on issues, review a list of new health concerns, or to get refills on medications, we will gladly see you today for these issues and reschedule your annual for another time. Are there any specific concerns or problems you would like addressed today?

2.

Any new chronic conditions/ major illnesses/ health problems/hospitalizations since your last annual?

3. Has anyone in your family been recently diagnosed with major medical problems (heart disease/ stroke/cancer/ diabetes, etc)?

4. Have you had any major life changes (marriage/divorce/ changed jobs/etc.) that would help us to get to know you better?

5. Health Habits:

Do you exercise regularly? No Yes- what kind and how often? _____ Do you eat healthy? No Yes

Are you taking calcium supplements? No Yes- what kind/dose? _____

How many serving of dairy do you consume daily? _____

Are you taking Vitamin D supplements? No Yes- what kind/dose? _____

Do you smoke or chew tobacco? No Yes- how much? _____ Do you drink alcohol? No Yes- How much? _____

Date of last Tetanus Vaccine: ___/___/___ Are you experiencing emotional or physical abuse? No Yes

Have you ever had an abnormal pap smear? No Yes-when? _____; For abnormality, please circle ALL that apply:

Colposcopy Biopsy Cryotherapy Surgery

Date of Last Menstrual Period: ___/___/___ or circle if any of the following apply: Hysterectomy or Post Menopausal

Have you been sexually active during the past year? No Yes—Please circle ALL that apply:

1 partner multiple partners male partner(s) female partners(s)

If yes, what birth control are you using? _____

If over the age of 40, when was your last mammogram? _____ results? _____

If over the age of 50, have you had a colonoscopy? No or Yes-results? _____

If over the age of 50, have you had a bone density? No or Yes-results? _____

6. Review of Systems: Please check and current or recent symptoms.

Chest Pain/Pressure	Depression	Coughing of Blood	Difficulty Emptying Bladder	
Tremor	Anxiety/Nervousness	Wheezing	Blood in Urine	

Leg Swelling	Trouble with Sleep	Congestion	Sores on Genitalia
Shortness of Breath	Fatigue	Heartburn	Sexual Difficulty
Heart Palpitations	Weight Gain	Indigestion	Painful Periods
Fainting/Blacking Out	Weight Loss	Diarrhea	Vaginal Discharge
Headaches	Easy Bruising/Bleeding	Constipation	Breast Discharge
Fever	Loss of Speech	Bloody/Black Stool	Breast Lumps
Night Sweats	Loss of Strength/ Weakness	Abdominal Pain/ Discomfort	Excessive Sweating
Acne	Vision Changes	Frequent Urination	Cold or Heat Intolerance
Mole Changes	Hearing Loss	Burning with Urination	Joint Pains
Skin Changes/Rash	Persistent Cough	Bladder Leakage	Back Pain
Other:			

7. Please list all CURRENT medications, including vitamins and supplements:

Medication/Supplement	Dosage	Frequency	Reason for Taking Medication

We want all of our patients to feel comfortable during their exam. Would you like another member of the medical staff to be present during your exam, in addition to Dr. Hausman-Cohen, Dr. Koren Weston, Laurelin Mullins, or Charis Bearden? Yes or No