INTERVAL HISTORY

Name:_____DOB:_____ Today's Date: _____

ADVANCED DIRECTIVE: Do you have an Advanced Directive/ Durable Power of Attorney for health care? □ Yes □ No

MEDICAL HISTORY: Please list all other doctors you see and the reason(s) you see them: _____
Any new diagnoses, hospitalizations, medical problems or surgeries since last physical: _____
_____

CURRENT MEDICATIONS: List all current medications, supplements and vitamins you are currently taking. (use back if needed)

Medication	Dose	How often you take it	What you take it for	When it was started	Refill needed?

WOMEN'S HEALTH:

Date of last pap test:	Ever had an abnormal pap: □ No □Yes, dates: Treatment:
Form of birth control:	Menstrual cycles are: □ Regular □ Irregular , explain: □ Menopause at age:
Date of last mammogram:	Date of last bone density test:

FAMILY HISTORY: Please check the boxes that apply to your family

Family member	**Alive**	**Year of birth**	**Breast cancer**	**Diabetes**	**Heart disease**	**Colon cancer**	**Asthma**	**Ovarian cancer**	**Other**
Father:	□								
Mother:	□								
Brother:	□								
Sister:	□								
Children	□								
Paternal Grandfather:	□								
Paternal Grandmother:	□								
Maternal Grandfather:	□								
Maternal Grandmother:	□								
Other:	□								

SOCIAL HISTORY:

Marital Status	□ Single □ Married □ Separated □ Divorced □ Widowed	Occupation:
Exercise (type, frequency)		
Tobacco	□ Yes □ Smoked in past, quit in _____. # of packs per day _____. # of years _____ Ready to quit? ____	
Alcohol	_____ glasses/day OR_____glasses/week. Problems due to alcohol? □ No □ Yes, explain: _____	
Recreational Drugs	□ No □ Yes, please explain: Ready to quit?	
Domestic Violence	Are you involved in domestic violence □ No □ Yes, please explain	

REVIEW OF SYSTEMS: Please check if you have any of the symptoms below **regularly or out of the ordinary**.

Constitution	□ blurring of vision	**Gastroenterology**	□ dryness	□ redness
□ headache	□ sudden blindness	□ abdominal pain	□ rash	□ cramps
□ dizziness	□ double vision	□ vomiting	□ bruising	□ muscle/tendon injury
□ fainting	**Endocrinology**	□ diarrhea	□ changing/new mole	**Psychiatry**
□ fatigue	□ excessive thirst	□ bloody or black stool	**Neurology**	□ nerves
□ weight change	□ cold intolerance	□ constipation	□ paralysis	□ depression
□ fever	□ heat intolerance	□ jaundice	□ numbness	□ insomnia
Ears/nose/throat	**Cardiology**	**Urology**	□ weakness	□ anxiety
□ hearing loss	□ chest pain	□ erectile dysfunction	□ convulsions	**Women's Health**
□ ringing in the ears	□ palpitations	□ burning	**Hematology/Lymph**	□ spotting
□ loss of balance	**Respiratory**	□ increased frequency	□ bleeding	□ painful intercourse
□ nose bleeds	□ cough	□ bloody or dark urine	□ swollen glands	□ severe cramps
□ chronic drainage	□ wheeze	□ incontinence	**Musculoskeletal**	□ breast lumps or pain
□ sore throat	□ shortness of breath	□ decreased flow	□ frequent back pain	□ excessive bleeding
□ difficulty swallowing	□ chronic phlegm	□ dribbling	□ sciatica	□ breast discharge
Eyes	□ coughing up blood	**Dermatology**	□ extremity swelling	□ vaginal discharge

OTHER CONCERNS YOU WOULD LIKE TO DISCUSS: _____
_____