LABEL

This form will aid in taking your medical history and it will become part of your permanent medical record. If you are uncomfortable answering any questions you can discuss them with your doctor or nurse.

Date: / / Age:_______

PATIENT INTAKE HISTORY

I (B) = (PFSH) Past Medical, Family & Social

(B1) IMMEDIATE FAMILY HISTORY

Has anyone in your family had any of the following health problems?
Include Mother **(M)** Father **(F)** Brother **(B)** Sister **(S)** Grandmother **(GM)** or Grandfather **(GF)**

	YES	NO	WHO		YES	NO	WHO		YES	NO	WHO
1 Diabetes				**11** Cancer (Other)				**19** Tuberculosis			
2 High blood Pressure				**12** Seizures/epilepsy				**20** Thyroid Disease			
3 High Cholesterol				**13** Mental Illness/Depression				**21** Birth Defects			
4 Heart Problems				**14** Kidney disease				**22** Multiple Pregnancy			
5 Stroke				**15** Arthritis				**23** Alzheimer's Disease			
6 Breast Cancer				**16** Osteoporosis				**24** Drinking or Drug Problem			
7 Colon Cancer				**17** Liver Disease/Hepatitis							
8 Cancer Ovarian/Uterus				**18** Lung Disease							

9 MOTHER: □ Living □ Deceased: - Cause: Age: **FATHER:** □ Living □ Deceased: - Cause: Age:

10 SIBLINGS: Number Living: Number Deceased: Cause(s)/Ages(s)

(B2) YOUR MEDICAL HISTORY:

	YES	NO		YES	NO		YES	NO		YES	NO
25 Anemia			**35** Breast lump/discharge			**45** Varicose Veins			**55** Do you Smoke?		
26 Contact Lenses			**36** Birth Defects			**46** Stomach/Intestinal problems			**56** Illicit drug use?		
27 Rubella			**37** High blood pressure			**47** Blood Transfusion			**57** Alcohol use?		
28 Severe Headaches			**38** Heart/Mitral Valve Prolapse			**48** Liver Disease			**58** Depression/Anxiety		
29 Stroke			**39** Rheumatic fever			**49** Tuberculosis			**59** Current Immunizations		
30 Diabetes			**40** Kidney disease			**50** Sexually Transmitted Disease			Tetanus		
31 Cancer			**41** Asthma			**51** HIV/AIDS			Hepatitis B		
32 Thyroid Disease			**42** Lung Disease			**52** Hepatitis A, B, C			Influenza		
33 Seizure/Epilepsy			**43** Blood Clots			**53** Domestic Violence			**60** Allergies?		
34 Collagen Disease/Lupus			**44** Broken Bones			**54** Arthritis/Back Pain					

61 Current Medications? (Name, dosage, who prescribed?)

62 Operations? (Type, date, surgeon, city) Anesthesia Complications: □ Yes □ No

63 Hospitalization (Reason/Date, Physician)

(B3) SOCIAL HISTORY

1 Occupation:
2 Years of Education:
3 # of People in Household:
4 □ Single □ Married □ Widow □ Divorced □ Separated

MENSTRUAL HISTORY if Menstruating	Yes	No	GYNECOLOGIC HISTORY	Yes	No	MENOPAUSAL HISTORY If Menopausal	Yes	No	MENOPAUSAL HISTORY (Cont)	Yes	No
64 Age of first period?			**71** Have you ever had sex?			**77** Age at Menopause?			**84** Have you used hormones?		
65 Are your periods Regular or Irregular?			**72** Are you sexually active now?			**78** Do you have hot flashes?			**85** Have you had Bone Density?		
66 Is your flow Normal / Light /Heavy?			**73** Do you/your partner use birth control?			**79** Do you have vaginal dryness?			**86** Have you had a Mammogram?		
67 Do you have cramps with your periods?			**74** Have you had an abnormal pap?			**80** Do you have urinary frequency/loss of urine?			**87** Have you had Colonoscopy?		
68 If YES: Mild/Moderate/Severe			**75** How many sexual partners (lifetime)?			**81** Do you have problems with low sex drive?			**88** Have you had Cholesterol test?		
69 Use medicine for Cramps?			**76** Do you have pain/bleeding with intercourse?			**82** Do you do monthly self breast exams?			**89** Pelvic Tumor/Fibroid?		
70 If so What?						**83** When was your last Pap?			**90** Tumor of the ovary?		

91 Pregnancy History:

Total # Pregnancies?	Elective Abortions?	Spontaneous Miscarriage?	Still born?
# Premature Births?	Ectopic?	Cesarean?	Total Living children?

Year	Weight	Sex Female/ Male		Hours Labor	Delivery Vaginal/ C-S		Attending Doctor / Complications	Anesthesia None/ Epidural/ General		
		F	M		V	C		N	E	G
		F	M		V	C		N	E	G
		F	M		V	C		N	E	G
		F	M		V	C		N	E	G
		F	M		V	C		N	E	G

I-B PFSH SUMMARY

1) Provider Signature/Date Reviewed:	NONE	NONE	Pertinent 1 AREA	Complete 2-3 AREAS	Transfer to Encounter
2) Provider Signature/Date Reviewed:	NONE	NONE	Pertinent 1 AREA	Complete 2-3 AREAS	
3) Provider Signature/Date Reviewed:	NONE	NONE	Pertinent 1 AREA	Complete 2-3 AREAS	
4) Provider Signature/Date Reviewed:	NONE	NONE	Pertinent 1 AREA	Complete 2-3 AREAS	

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Patient's Signature/Date:_______________________________

I (C) ROS (Check all that apply)	NOW	PAST	NOT SURE
1 CONSTITUTIONAL	□None		
Weight Loss	□	□	□
Weight Gain	□	□	□
Fever	□	□	□
Fatigue	□	□	□
Change in Height	□	□	□
2 EYES	□None		
Double Vision	□	□	□
Spots before eyes	□	□	□
Vision Changes	□	□	□
Glasses/Contacts	□	□	□
3 EAR, NOSE AND THROAT	□None		
Earaches	□	□	□
Ringing in Ears	□	□	□
Hearing Problems	□	□	□
Sinus Problems	□	□	□
Sore Throat	□	□	□
Mouth Sores	□	□	□
Dental Problems	□	□	□
4 CARDIOVASCULAR	□None		
Painful Breathing	□	□	□
Chest Pain or Pressure	□	□	□
Difficulty Breathing on Exertion	□	□	□
Swelling of Legs	□	□	□
Rapid or Irregular Heartbeat	□	□	□
5 RESPIRATORY	□None		
Wheezing	□	□	□
Spitting up Blood	□	□	□
Shortness of Breath	□	□	□
Chronic Cough	□	□	□
6 GASTROINTESTINAL	□None		
Frequent Diarrhea	□	□	□
Bloody Stool	□	□	□
Nausea/Vomiting/Indigestion	□	□	□
Constipation	□	□	□
Involuntary loss of gas or stool	□	□	□
7 Genitourinary	□None		
Breasts: Pain in Breast	□	□	□
Nipple Discharge	□	□	□
Lumps	□	□	□
Blood in Urine	□	□	□
Pain with Urination	□	□	□
Strong Urgency to Urinate	□	□	□
Frequent Urination	□	□	□
Incomplete Emptying	□	□	□
Involuntary/Unintended urine loss	□	□	□
Urine loss when coughing or lifting	□	□	□
Abnormal Bleeding	□	□	□
Painful Periods	□	□	□
Premenstrual Syndrome (PMS)	□	□	□
Painful Intercourse	□	□	□
Fibroids	□	□	□
Infertility	□	□	□
DES Exposure	□	□	□
Abnormal Vaginal Discharge	□	□	□

	NOW	PAST	NOT SURE
8 MUSCULOSKELETAL	□None		
Muscle Weakness	□	□	□
Muscle or Joint Pain	□	□	□
9 INTEGUMENTARY	□None		
Skin: Rash	□	□	□
Sores	□	□	□
Dry Skin	□	□	□
Moles	□	□	□
10 NEUROLOGICAL	□None		
Dizziness	□	□	□
Seizures	□	□	□
Numbness	□	□	□
Trouble Walking	□	□	□
Severe Memory Problems	□	□	□
Frequent or Severe Headaches	□	□	□
11 PSYCHIATRIC	□None		
Depression or Frequent Crying	□	□	□
Severe Anxiety	□	□	□
12 ENDOCRINE	□None		
Hair Loss	□	□	□
Heat/Cold intolerance	□	□	□
Abnormal Thirst	□	□	□
Hot Flashes	□	□	□
13 HEMATOLOGICAL/LYMPHATIC	□None		
Frequent Bruises	□	□	□
Cuts do not stop Bleeding	□	□	□
Enlarges Lymph nodes (Glands)	□	□	□
14 ALLERGIC/IMMUNOLOGIC □None			
Medication Allergies	□	□	□
If any, Please list allergy & Type of Reaction			
Other Allergies	□	□	□

Patient's Signature/Date

Form Completed by: □ Patient □ Office Nurse □ Provider □ Other

Comments:

1) Provider Signature/Date Reviewed:

2) Provider Signature/Date Reviewed:

3) Provider Signature/Date Reviewed:

4) Provider Signature/Date Reviewed:

Remark as appropriate on H & P