KATHERINE L. BOYD, M.D.,PC.,F.A.C.O.G.
BOARD CERTIFIED IN OBSTETRICS AND GYNECOLOGY
28755 SCHOENHERR SUITE 200 WARREN MI 48088
Telephone (586) 573-7222 FAX (586) 573-7267
www.kathboyd.com

MEDICAL HISTORY REVIEW

Since your last visit have you had any of the following?

___Weight loss	___Abnormal Bleeding	___Breast Pain
___Weight Gain	___Pelvic Pain	___Nipple Discharge
___Vision changes	___Muscle Weakness	___Seizures
___Headaches	___Urinary Incontinence	___Hot Flashes
___Sinus problems	___Urinary Frequency	___Night Sweats
___Chest Pain	___Diarrhea	___Cough
___Edema	___Abdominal Pain	___Wheezing
___Allergic Reaction	___Hospitalizations	___Major Illness
___Surgery	___Injuries	___Physically Abused
___Living Will	___Depression	

Has anyone in your family been diagnosed with the following?

___Diabetes	___Cancer	___Heart Disease
___High Cholesterol	___Hypertension	

Do you?

___Smoke	___Use Alcohol	___Use street Drugs
___Use Seat Belts	___Exercise Regularly	

Do you have any problems or concerns?_____
_____

Is this a new or old problem?_____
When did it start?_____
Describe yours signs and symptoms_____
Have you tried anything to fix the problem?_____

Your exam ***may*** include but is ***not limited to*** Physical exam, Pap smear, Gonorrhea and Chlamydia culture, Stool hemoccult, Wet mount and Breast exam. Not all Insurances cover screening exams and testing. ***If the claim is rejected, you will be responsible for the fee.*** You must inform us below if you do not want a procedure done.

*I request that*_____ *not be performed.*

Signature_____Date _____