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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 ___Physical Abuse

___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 ___ Wear a Bike Helmet

Do you have any problems or concerns? _____

_____

Is this a new or old problem? _____

When did it start?_____

Describe your 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, chlamydia and trichomonas culture, bacterial culture, candida 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_____