

**Family History**

<u>Condition</u>	<u>Relative(s)</u>	<u>Condition</u>	<u>Relative(s)</u>
Blood clots	_____	High blood pressure	_____
Breast cancer	_____	Kidney disease	_____
Colon cancer	_____	Muscular dystrophy	_____
Cystic fibrosis	_____	Osteoporosis	_____
DES exposure	_____	Ovarian cancer	_____
Diabetes	_____	Spina bifida	_____
Down's syndrome	_____	Strokes	_____
Heart disease	_____	Other: _____	

**Review of Systems** (check symptoms you currently have)

**Gynecological**

- Hot flashes
- Breast lump
- Nipple discharge
- Abnormal uterine bleeding
- Abnormal vaginal discharge
- Vaginal itching or burning
- Pelvic pain

**General**

- Fever
- Fatigue
- Recent weight change
- Headaches
- Depression

**Eye, Ear, Nose, Throat**

- Visual changes
- Hearing loss
- Ear pain

- Sinus problem
- Nosebleeds
- Bleeding gums
- Swollen glands

**Cardiovascular, Respiratory**

- Chest pain
- Shortness of breath with exertion
- Palpitation or irregular heart beat
- Swelling of feet or ankles
- Chronic cough
- Wheezing

**Genito-Urinary**

- Blood in urine
- Frequent urination
- Painful urination
- Lack of bladder control

**Gastrointestinal**

- Loss of appetite

- Abdominal pain
- Change in bowel movement
- Diarrhea
- Constipation
- Nausea or vomiting
- Rectal bleeding
- Vomiting blood

**Musculoskeletal**

- Joint pain
- Muscle or joint weakness
- Muscle or joint pain
- Back pain
- Numbness

**Skin**

- Rash or itching
- Change in mole(s)
- Sore that won't heal

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I certify that I have answered the questions on this form to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status.

Signature of patient or guardian \_\_\_\_\_ Date \_\_\_\_\_