Fair Oaks Women's Health
Obstetrics and Gynecology
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Fair Oaks Women's Health
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INTERVAL HISTORY FORM

This form helps to keep us up to date with your health.
All your medical information is kept strictly confidential. Thank you.

Name: ____________________ Date: ____________

Date of Birth: ____________ email: ____________________

1st day of Last Period (LMP):________ **Birth Control Method:** ________

Current Medication, Vitamins, Supplements: ____________________

____

Since your last visit, have you had surgery or been diagnosed with a new condition?

Explain: ______________________________

____

Current: Smoking: __________ **Alcohol:** ______________

Exercise (type and how often):______________________

Colonoscopy (ever? last one when?): ____________________

Bone Density (ever? last one when?): ____________________

Mammogram (ever? last one when?): ____________________

Primary Care Provider (from History Update):____________________

FAMILY HISTORY (only enter CHANGES since your last exam)

Please indicate any major health conditions affecting (or affected) any close family members. Examples of major conditions are cancer, heart disease, high blood pressure, stroke, high cholesterol, thyroid disease, osteoporosis, mental illness, auto-immune diseases or any genetic or inheritable condition. Note if they have passed, at what age were they?

Mother or Father: ______________________________

Sisters or Brothers: ______________________________

Your biological children: ______________________________

Grandparents (which side): ______________________________

Aunts or Uncles: ______________________________

Details: ______________________________

____

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REVIEW OF SYSTEMS

(Are you currently experiencing any of the following symptoms to a significant degree?)

General
____ Fatigue or Weakness
____ Fever, Chills or Sweats
____ Unexplained weight gain or loss

Skin
____ Lesions, Moles or Sores
____ Rash

Eyes, Ears, Nose and Throat
____ Sore Throat
____ Trouble Swallowing
____ Vision or Hearing Changes
____ Nose Bleeds

Breasts
____ Breast Lump or Lumps
____ Breast Pain or Tenderness
____ Nipple Discharge (other than white)

Cardiovascular
____ Chest Pain or Tightness
____ Irregular Heartbeat or Palpitations

Respiratory
____ Chronic Coughing
____ Shortness of Breath or Wheezing

Gastrointestinal
____ Heartburn
____ Nausea or Vomiting
____ Diarrhea (watery stool)
____ Severe Constipation
____ Abdominal Pain
____ Rectal Bleeding

Urinary
____ Burning with Urination
____ Urgency and/or Frequency of Urination
____ Leakage of Urine
____ Waking at night 2 or more times to urinate

Gyn (also see Menstrual History ahead)
____ Genital sores, lesions or bumps
____ Irregular periods
____ Bleeding Between Periods
____ Pain Before or During Periods
____ Vaginal Itching, Burning or Dryness
____ Vaginal Discharge
____ Vaginal Dryness
____ Pain during intercourse
____ Vulvar Pain
____ Severe PMS Symptoms

Endocrine (Glandular)
____ Menopause Symptoms (hot flashes)
____ Intolerance to Heat or Cold
____ Low Sex Drive
____ Excessive Hair Loss
____ Excessive Hair Growth

Musculoskeletal
____ Joint Pain (Back, Knee, Wrist, Hip)
____ Joint Swelling
____ Muscle Cramping or Pain

Hematologic
____ Swollen Glands
____ Easy/Frequent Bruising

Neurologic
____ Dizziness
____ Headaches
____ Numbness
____ Memory Problems

Psychiatric
____ Excessive Anxiety, Worries, Stress
____ Severely Depressed
____ Insomnia

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