
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: (first and last name please): _____

FAMILY HISTORY (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: _____

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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