Fair Oaks Women's Health
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Fair Oaks Women's Health
Convenience • Caring • Cutting-Edge

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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?): _____

FAMILY HISTORY

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 <u>to a significant degree</u>?)

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

Skin
- ____ Itching or Rash
- ____ Moles or Sores

Breasts
- ____ Breast Lump
- ____ Breast Pain
- ____ Nipple Discharge (other than white)

Heart
- ____ Chest Pain or Tightness
- ____ Irregular Heartbeat or Palpitations

Lungs
- ____ Chronic Cough
- ____ Hurts to Breath
- ____ Shortness of Breath

Gastrointestinal (GI)
- ____ Nausea, Vomiting or Diarrhea
- ____ Heartburn
- ____ Severe Constipation

Gynecology
- ____ Bleeding After Intercourse
- ____ Bleeding Between Periods
- ____ Bumps or Sores in Genital Area
- ____ Heavy Flow > than 3 days per period
- ____ Irregular Periods
- ____ Pain Before or During Periods
- ____ Pain with Intercourse
- ____ Pain with Ovulation
- ____ Periods longer than 8 days
- ____ Severe Pain/Cramps with Periods
- ____ Severe PMS Symptoms
- ____ Vaginal Discharge
- ____ Vaginal Dryness, Itching or Irritation
- ____ Vaginal OdorUrinary
- ____ Burning with Urination
- ____ Leakage of Urine
- ____ Urgency or Frequent Urination
- ____ Waking at night 2 3 times to urinate

Neurologic
- ____ Dizzy or Lightheaded
- ____ Headaches (especially if new)
- ____ Memory Problems

Psychiatric
- ____ Severe Anxiety, Worry or Stress
- ____ Very Depressed or Sad
- ____ Suicidal thoughts

Endocrine (Glandular)
- ____ Excessive Hair Growth
- ____ Excessive Hair Loss
- ____ Intolerance to Heat or Cold
- ____ Low Sex Drive

Other Unusual Symptoms (please list)

_____

_____

_____

_____

_____

_____

_____

_____

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