

PATIENT HISTORY AND SYSTEMS REVIEW FORM

DATE: _____

NAME: _____

PAST HISTORY

CHART #: _____

If you ever had or presently have any of these problems, please check:

- Bronchial Asthma, Blood Clots, Heart Disease or heart attacks, High Blood Pressure, Anemia or Blood problems, Thyroid or other hormone problems, Diabetes or Low Blood Sugar, Back problems, Brain or spinal cord problems, Cancers or Tumors, Female Problems, V.D. (gonorrhoea, syphilis, etc), Other illness, Ever been in the hospital, Dates & kinds of operations

SYSTEM REVIEW

If you are having any of these problems, or recently had any of these problems, please check and tell when and how long you have had them:

- Nausea, Headaches, Leg Cramps, Breast Tenderness, Depression, Chest Pain, Vaginal or Penile discharge, Blurred Vision, Dizziness, Fainting Spells, Shortness of breath, Problems with sex organs, Frequent or painful Urination, Varicose Veins, Hemorrhoids, Hot flashes, Skin rashes

SOCIAL HISTORY AND DRUG HISTORY

- Do you smoke? YES NO How much a day, Do you drink alcohol? YES NO How much a day, Do you take street drugs? YES NO What kind, Do you wear seat belts? YES NO Allergy to Medicine? What?, Have you been exposed to AIDS? YES NO Taking Medicine?

OBSTETRICAL AND GYNECOLOGICAL HISTORY

A. MENSES

Age period began, An irregularity, Amount: Slight Medium Heavy, Date of last period, Days of flow, Painful periods

B. PREGNANCY AND CONTRACEPTIVE HISTORY

Number of pregnancies and dates, Number of miscarriages, Number of abortions, Number of premature, Number of stillborn, Number of full term, Number of children, Problems during pregnancy, Problems during delivery, Are you currently using a birth control method? Yes No If yes, what?, List other method used, Problems of these methods

FAMILY HISTORY(include mother, father, grandmother, grandfather, brothers, sisters, etc)

- Heart Disease, Diabetes, Cancer, Strokes, Seizures, Mental retardation, High Blood Pressure, Tuberculosis, lung disease, Cataracts, Glacoma, Psychiatric problems, Other (specify)

CANCER RISK COUNSELING

SBE Taught By: Date: Reviewed By: Date:

I CONSENT TO TREATMENT, WITNESS: