

Annual Health Patient Information

Place label

Family History: Do your parents or siblings have any medical problems? If so explain:

Mother: _____
Father: _____
Sisters: _____
Brothers: _____

Please circle if anyone in your family has been diagnosed with: high blood pressure, stroke, blood clot or clotting disorder, heart attack before age 50, cancer, diabetes, thyroid disease, depression

Review of systems. Circle any that have been present for **more than 4 weeks.**

General: Unexplained weight loss or gain, fatigue, fevers, night sweats

Skin: Changes in existing moles, unusual looking new moles, poorly healing wounds, rashes

Head/Neck: Blurred vision, double vision, sores in mouth

Cardiac: Chest pain, racing or irregular heart beat

Pul: Cough, wheeze, shortness of breath with activity

GI: diarrhea, constipation, change in bowel habits, blood in stool or black stools, abdominal pain

GU: Pain with urination, blood in urine, frequent UTIs, vaginal discharge, pain with sex, genital bumps

Breasts: Pain in breast, lumps, nipple discharge

M/S: Unexplained muscle or joint pain, swelling, limitations in normal activities

Neuro: Frequent headaches, fainting, blackouts, seizures, weakness, numbness, tingling

Psych: Depression, anxiety, mood swings, feeling persistently down in the dumps, thoughts of suicide

GYN History:

How old were you when you got your first period? _____

Do you have problems with your period? Yes/no

When was the first day of your last period? _____

Have you ever been diagnosed with a sexually transmitted infection? Yes/no if yes circle below
HPV, warts, herpes, Chlamydia, gonorrhea, HIV, trichomonas, syphilis

Have you ever been pregnant? Yes/no

What are you using to prevent pregnancy? Please circle below or list name of contraceptive:

Nothing, condoms, pulling out, birth control pills, nuvaring, depoprovera, the "patch"

Have you ever had an abnormal pap smear? Yes/no

Student signature _____ **Date** _____