Family History

Please list any close relatives with a history of the following:

	Relative/Age at Diagnosis		Relative
❑ Breast cancer		❑ High blood pressure	
❑ Ovarian cancer		❑ Diabetes	
❑ Uterine cancer		❑ Heart Disease (heart attack,	
❑ Colon cancer		stroke, bypass surgery)	

Social History

Alcohol use	❑ Yes	❑ No	If yes, _____drink(s) per day/week/month
Tobacco use	❑ Yes	❑ No	If yes, _____ pack(s) per day for _____ years
Street drug use	❑ Yes	❑ No	Type and frequency_____
Exercise	❑ Yes	❑ No	Type and frequency_____
Caffeine	❑ Yes	❑ No	If yes, _____ caffeinated drinks (coffee, tea, soda) per day/week
Sexual Abuse	❑ Yes	❑ No	If yes, are you safe now? ☐yes ☐no Counseling? ☐yes ☐no
Physical Abuse	❑ Yes	❑ No	If yes, are you safe now? ☐yes ☐no Counseling? ☐yes ☐no
Emotional Abuse	❑ Yes	❑ No	If yes, are you safe now? ☐yes ☐no Counseling? ☐yes ☐no

Review of Systems Do you currently have any of the following?

	Comments
☐Y ☐N	Generally healthy
☐Y ☐N	Recent weight gain or loss of 25 lbs.
☐Y ☐N	Fever
☐Y ☐N	Vision problems (excluding glasses)
☐Y ☐N	Sinus problems
☐Y ☐N	Hearing loss
☐Y ☐N	Chest pain
☐Y ☐N	Varicose veins
☐Y ☐N	Shortness of breath
☐Y ☐N	Chronic cough
☐Y ☐N	Diarrhea
☐Y ☐N	Constipation
☐Y ☐N	Blood in stools
☐Y ☐N	Heartburn/reflux
☐	None of the above

	Comments
☐Y ☐N	Frequent urination
☐Y ☐N	Burning with urination
☐Y ☐N	Incontinence
☐Y ☐N	Urgency
☐Y ☐N	Bladder infection
☐Y ☐N	Stomach pains
☐Y ☐N	Vaginal discharge
☐Y ☐N	Irregular vaginal bleeding
☐Y ☐N	Pelvic pain
☐Y ☐N	Painful intercourse
☐Y ☐N	Breast lumps
☐Y ☐N	Back pain
☐Y ☐N	Joint/muscle pain
☐Y ☐N	Depression/anxiety
☐	None of the above

Patient Signature_____ Date_____

Clinician Signature_____ Date_____

Annual Review #2 Clinician Signature_____ Date_____

Annual Review #3 Clinician Signature_____ Date_____