Seasons Healthcare for Women

Patient Name: _____ DOB: _____ Patient No: _____

Physician: _____ Date of last menstrual cycle: _____

Chief Complaint/Main reason for today's visit: _____

Please list any physicians you would like to receive a report of today's visit: _____

ESTABLISHED PATIENT HEALTH HISTORY UPDATE

PAST MEDICAL HISTORY

Since your last visit to , are you being treated for any new symptoms or diagnoses? Yes / No
If yes, please list: _____

Have you had any surgeries, procedures, or hospitalizations since your last visit? Yes / No
If yes, please list (include) location and dates: _____

MEDICATION HISTORY

Have you acquired any new allergies since your last visit? Yes / No
If yes, please list: _____

Please list your medications (prescription and over the counter) with doses and frequency: _____

REVIEW OF SYSTEMS

Have any family members been diagnosed with a significant medical problem? Yes / No
Please Elaborate: _____

Have there been any changes in your employment or home life? Yes / No
Please Elaborate: _____

SINCE YOUR LAST VISIT, HAVE YOU HAD ANY OF THE FOLLOWING?

CONSTITUTIONAL	Circle One:
Weight loss	YES NO
Weight gain	YES NO
Fever	YES NO
Fatigue	YES NO

CARDIOVASCULAR	Circle One:
Chest pain	YES NO
Difficult breathing on exertion	YES NO
Swelling of legs	YES NO
Palpitations of heart	YES NO
High blood pressure	YES NO

RESPIRATORY	Circle One:
Shortness of breath	YES NO
Chronic cough *more than 3 weeks*	YES NO

HEMATOLOGIC/SKIN	Circle One:
Frequent bruises	YES NO
Swollen glands	YES NO

GENITOURINARY	Circle One:
Blood in urine	YES NO
Pain with urination	YES NO
Urine loss when straining	YES NO
Abnormal discharge	YES NO
Abnormal periods/bleeding	YES NO
Painful periods	YES NO
PMS	YES NO
Painful intercourse	YES NO
Problems getting pregnant	YES NO

MUSCULOSKELETAL	Circle One:
Muscle weakness	YES NO
Joint, neck, or back pain	YES NO

GASTROINTESTINAL	Circle One:
Frequent diarrhea	YES NO
Blood in stool	YES NO
Abdominal pain	YES NO
Indigestion/heartburn	YES NO
Nausea/vomiting	YES NO
Constipation	YES NO

ENDOCRINE	Circle One:
Dry skin	YES NO
Abnormal thirst	YES NO
Hot flashes	YES NO
Too hot/cold	YES NO
Tired/sluggish	YES NO

NEUROLOGICAL	Circle One:
Numbness/tingling	YES NO
Trouble walking	YES NO

PSYCHIATRIC	Circle One:
Are you generally satisfied with your life?	YES NO
Depression	YES NO
Frequent crying	YES NO
Do you hear voices?	YES NO
Have you considered suicide?	YES NO
Have you considered murder?	YES NO

BREAST	Circle One:
Pain in breast	YES NO
Nipple discharge	YES NO
Lumps/masses in breast	YES NO

Patient Note Section –
Please elaborate on any of the above as needed:

_____

_____

_____

_____

PATIENT'S SIGNATURE _____ **DATE** _____

PROVIDER'S SIGNATURE _____ **DATE** _____