

### Family History

Have your parents, siblings or children had the following:

	Yes	No	Relation
Breast Cancer	_____	_____	_____
Colon Cancer	_____	_____	_____
Ovarian Cancer	_____	_____	_____
Uterine Cancer	_____	_____	_____
Recurrent miscarriage	_____	_____	_____
Infertility	_____	_____	_____
Diabetes	_____	_____	_____
Endometriosis	_____	_____	_____
Fibroids	_____	_____	_____
Heart Disease	_____	_____	_____
Kidney Disease	_____	_____	_____
Depression	_____	_____	_____
Other (Please explain)	_____	_____	_____

### Past Medical History

	Yes	No	Year/Description
Epilepsy/Seizures	_____	_____	_____
Other Neurological Disorders	_____	_____	_____
Tuberculosis	_____	_____	_____
Anemia	_____	_____	_____
Sickle Cell	_____	_____	_____
Heart Disease	_____	_____	_____
Clots in Legs/Lungs	_____	_____	_____
Kidney Disease	_____	_____	_____
Headaches/Migraines	_____	_____	_____
Thyroid Disorder	_____	_____	_____
High Blood Pressure	_____	_____	_____
Arthritis	_____	_____	_____
Autoimmune Disorder (Lupus)	_____	_____	_____
Depression/Postpartum Depression	_____	_____	_____
Asthma	_____	_____	_____
Diabetes	_____	_____	_____
Recurrent Urinary Tract Infections	_____	_____	_____
Hepatitis/Liver Disease	_____	_____	_____
Herpes	_____	_____	_____
Ulcers/Bowel Disease	_____	_____	_____
History of blood transfusion	_____	_____	_____
Rh (D) Sensitized	_____	_____	_____
Seasonal Allergies	_____	_____	_____
Breast Cancer	_____	_____	_____
HIV	_____	_____	_____
Chicken Pox	_____	_____	_____

Are your immunizations up-to-date?

Date of last tetanus

\_\_\_\_\_

## Family Planning

Please check any method of contraceptive you have used in the past:

- |  |                                       |  |                                     |
|--|---------------------------------------|--|-------------------------------------|
| <input type="checkbox"/> Birth Control Pills       | <input type="checkbox"/> Condoms      | <input type="checkbox"/> Depo-Provera/other injectable |                                     |
| <input type="checkbox"/> IUD (Intrauterine Device) | <input type="checkbox"/> Diaphragm    | <input type="checkbox"/> Withdrawal                    | <input type="checkbox"/> Spermicide |
| <input type="checkbox"/> Patch                     | <input type="checkbox"/> Vaginal Ring | <input type="checkbox"/> Tubal Ligation                | <input type="checkbox"/> Vasectomy  |
| <input type="checkbox"/> None                      | <input type="checkbox"/> Other        |  |                                     |

(Describe: \_\_\_\_\_)

Please check any method of Natural Family Planning you have used in the past:

- None
- Sympto-thermal (please circle: CCL Northwest Family Services)
- Ovulation Method (please circle: Billings FAF Creighton)
- Calendar/Rhythm

Which method do you currently use?

\_\_\_\_\_

# Review of Systems

## General

- Fatigue
- Weight gain
- Weight loss
- Fever
- Hot flashes

## Endocrine

- Sensitivity to hot
- Sensitivity to cold
- Excessive thirst
- Abnormal hair growth
- Hair loss

## Neuro

- Headaches
- Seizures
- Loss of strength
- Loss of sensation

## Skin

- Rash
- Moles (growth/change)
- Acne

## Eyes

- Visual changes
- Seeing spots or lights

## ENT

- Sore throats
- Nasal congestion

## Respiratory

- Cough
- Difficulty breathing

## Heart

- Chest pain
- Palpitations

## Breasts

- Breastfeeding
- Mass or lump
- Nipple discharge
- Breast tenderness
- Perform self-breast
- Other

## Gastrointestinal

- Abnormal pain
- Nausea
- Vomiting
- Diarrhea
- Constipation
- Heartburn
- Blood in stool

## GYN

- Vaginal discharge
- Vaginal burning/pain
- Vaginal bulge
- Vaginal /vulvar itching
- Pelvic pain/pressure
- Abnormal bleeding
- Other\_\_\_\_\_

## Urology

- Painful /burning urination
- Blood in urine
- Leakage or loss of urine

## Musculoskeletal

- Muscle pain
- Joint pain

## Mood

- Depressed
- Anxiety
- Mood swings

## Hematology

- Easy bruising
- Frequent nosebleeds

I verify that the information I have provided is accurate to the best of my knowledge.

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Patient Signature

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Date