CONFIDENTIAL PERSONAL HEALTH INVENTORY

No. ____________

Name ______________________________ Age ____ Occupation ____________________ Date ____________

Education: High School ____ College ____ Grad. Ed. ____

Address ______________________________ Birthdate ____________ Phone ____________
Street City Zip

C C

Check ☑ Single ☐ Married (____ Years ☐ Widow ☐ Divorced ☐ Separated ☐

Married more than once ☐ Yes ☐ No How many times. ______

Reason you came to see the doctor: ____

OBSTETRIC HISTORY: Number of times pregnant ______ Full Term ______ Prematures ______
Miscarriages/abortions ______ Stillborns ______ Living children ______ G____ P____ AB____

List complications with any pregnancy ____

HISTORY OF PRESENT ILLNESS

MENSTRUAL HISTORY (Skip entire section if you had hysterectomy)

Menses started at the age of ____________ Became regular at the age of ____________

Last menstrual period started ____________ 19 ______ ☐ Normal ☐ Abnormal

Interval between periods are ____________ days and duration ____________ days.

Usually periods ☐ Regular ☐ Somewhat Regular ☐ Irregular

Menstral Flow ☐ Scant ☐ Moderate ☐ Heavy

Clots ☐ Yes ☐ No

Painful Periods ☐ Yes ☐ No Mild ☐ Moderate ☐ Severe ☐ How long? ____________

OTHER SYMPTOMS (Associated with periods)

Intermenstrual Spotting/Bleeding	☐ Yes	☐ No	☐ Sometimes
Bleeding or Spotting after intercourse	☐ Yes	☐ No	☐ Sometimes
Painful Intercourse	☐ Yes	☐ No	☐ Sometimes

GYN HISTORY

Last Paps Smear. Date ____________ Where ____________ ☐ Normal ☐ Abnormal

History of Vaginal Herpes Infection	☐ Yes	☐ No
Milky discharge from the breasts	☐ Yes	☐ No
Do you have vaginal discharge	☐ Yes	☐ No
Odor	☐ Yes	☐ No
Itching/Burning	☐ Yes	☐ No
Do you have premenstrual tension	☐ Yes	☐ No

PREMENSTRUAL SYNDROME

Many of the following symptoms may be experienced during the menstrual cycle.
Please check those boxes that describes your feelings at that time.

☐ Moodiness	☐ Depression	☐ Unusual food cravings	☐ Backache
☐ Restlessness	☐ Anxiety	☐ Fatigue	☐ Uterine cramps
☐ Forgetfulness	☐ Hostility	☐ Headache	☐ Bowel cramps
☐ Confusion	☐ Panic	☐ Slow and deliberate	☐ Constipation
☐ Irritability	☐ Despair	☐ Uncoordinated	☐ Diarrhea
☐ Unfriendliness	☐ Wanting to run away	☐ Bloated abdomen	☐ Altered sexual drive
☐ Tension	☐ Suicidal thoughts	☐ Increased body weight	☐ Non-specific itching
☐ Loneliness	☐ Well-being	☐ Breast pain	☐ Aggrevation of asthma
☐ Crying spells			

Symptoms are present during:

☐ 7-8 days before menses, ending 2-3 days after menses. (I)
☐ As above and 3-4 days mid-cycle. (I)
☐ 3-4 days after mid-cycle and ending 5 days before menses (II)
☐ Almost all the time

Are you disatisfied with work?	☐ Yes	☐ No
family?	☐ Yes	☐ No
marriage?	☐ Yes	☐ No

Do you wish to discuss marital or sexual problems? ☐ Yes ☐ No

Did your mother take female hormones when she was pregnant? DES ☐ Yes ☐ No

CONTRACEPTION – Check method used:

Diaphragm ______ Condom ______ Rhythm ______ Withdrawal ______ Foam ______ IUD ______

Birth control pills ______ Name ____________ Vasectomy ______ Tubal Ligation ______ When? ______

GU HISTORY

Do you have painful urination?	☐ No	☐ Mild	☐ Moderate	☐ Severe
	☐ Initially	☐ Terminally		
Have you noticed blood in urine?	☐ Yes	☐ No		
Urination during night	☐ Yes	☐ No	______ times per night	

DO YOU LOSE URINE ON:

sneezing/coughing/jumping? ☐ Yes ☐ No If yes, no. of years symptoms present____ years.

If above symptoms are significant, please ask the nurse for additional questionnaire.

Have you noticed any protrusion in the vagina?	☐ Yes	☐ No
Do you have bearing down sensation?	☐ Yes	☐ No
Do you have low back discomfort?	☐ Yes	☐ No
Do you have sensation of incomplete emptying of the bladder?	☐ Yes	☐ No
Do you ever have to suddenly rush to go to the bathroom?	☐ Yes	☐ No

---

SURGICAL HISTORY

CHECK OPERATIONS PERFORMED:

Operation	Date	Operation	Date
Appendix	________	D & C	________
Gall Bladder	________	C-Section	________
Kidney Stones	________	Hysterectomy	________
Tonsils	________	Vaginal Repair	________
Varicose Veins	________	Hemorrhoids	________
Breast	________	Diagnostic Laparoscopy	________
Skin Lumps/Moles	________	Exploratory Surgery	________
Tumors of any kind	________	Thyroid	________
		Other	________

PAST HISTORY

HAVE YOU EVER HAD?

	Yes	No		Yes	No
Rheumatic Fever	☐	☐	Diabetes	☐	☐
Heart Disease	☐	☐	Blood Transfusion	☐	☐
High Blood Pressure	☐	☐	Hepatitis/Jaundice	☐	☐
Thyroid Disease	☐	☐	Epilepsy	☐	☐
X-Ray treatment to the neck in youth	☐	☐	Syphilis	☐	☐
			Gonorrhea	☐	☐
Thrombolphlebitis	☐	☐	Tuberculosis	☐	☐
Drug or food insensitivity	☐	☐	Kidney Disease	☐	☐
Ulcer	☐	☐	Anemia	☐	☐
Cancer	☐	☐	Asthma	☐	☐

Any other major illnesses ______________________________

FAMILY HISTORY

HAS A MEMBER OF YOUR FAMILY EVER HAD?

	Yes	No		Yes	No
Cancer	☐	☐	High Blood Pressure	☐	☐
Diabetes	☐	☐	Reaction to Anesthesia	☐	☐
Tuberculosis	☐	☐	Blood related Diseases	☐	☐
Heart Disease	☐	☐	Family History of Birth Defects	☐	☐
Kidney Disease	☐	☐			

	Living	Deceased	Cause
Father	☐	☐	______________________
Mother	☐	☐	______________________
Brothers	☐	☐	______________________
Sisters	☐	☐	______________________

	No	Yes	
Do you habitually use laxatives?	☐	☐	How much? ____________
Do you use Alcohol?	☐	☐	How much? ____________
Do you use Tobacco?	☐	☐	How much? ____________
Have you lived in a foreign country?	☐	☐	

MEDICAL–ALLERGY

Have you ever had any REACTION or SIDE EFFECTS from DRUGS, VACCINES, CHEMICALS or other AGENTS?

____

List any TABLETS, PILLS, CAPSULES you are NOW taking:

____

____

REVIEW BY SYSTEMS

HAVE YOU EVER HAD ANY OF THE SYMPTOMS LISTED BELOW?

SKIN AND LYMPH NODES	Yes	No
Any unexplained itching	☐	☐
Unexplained sweating or fever during the night which lasted for more than 2 weeks	☐	☐
Swelling or enlargement (painful or not) of lymph glands	☐	☐
Non-healing ulcers, sores, or growths which have lasted for more than a month	☐	☐
Red scaling patches of skin which do not heal	☐	☐
Any moles which have changed color, changed size, become ulcerated (sore) or bleed	☐	☐

HEAD AND NECK	Yes	No
Sores or white spots in the mouth lasting for one month or more	☐	☐
Fullness, soreness, or swelling in the lower front of the neck	☐	☐
Hoarseness or changes in the voice	☐	☐
Difficulty in swallowing lasting one month or more	☐	☐
Any irritation in the mouth due to poor-fitting dentures or sharp teeth	☐	☐
Any small solid lump in the neck area	☐	☐

RESPIRATORY SYSTEM	Yes	No
A cough, producing sputum (mucus from the lungs), which has lasted more than a month	☐	☐
Sputum which is streaked with blood	☐	☐
Chest colds more than 3 times a year	☐	☐
Chest pain in the same area which has lasted more than one month	☐	☐

CARDIOVASCULAR SYSTEM	Yes	No
Shortness of breath for no apparent reason	☐	☐
Palpitations of the heart	☐	☐
A squeezing or pressing feeling in the mid-portion of your chest	☐	☐
Swelling of both ankles	☐	☐
Phlebitis (inflammation of the veins) more than once	☐	☐
Unexplained dizzy spells	☐	☐

GASTROINTESTINAL TRACT	Yes	No
Heartburn, indigestion or abdominal pain which has lasted for more than 1 month	☐	☐
Nausea or vomiting which has lasted more than one week	☐	☐
Fullness after eating small amounts	☐	☐
Unexplained weight loss or gain, more than 10 lbs. in three months or less	☐	☐
Any vomiting of blood	☐	☐
Bowel movements more frequently or less frequently than usual	☐	☐
Increasing narrowness of stool (ribbon-like)	☐	☐
Pain in rectum with bowel movements	☐	☐
Blood in stool, or tarry-black stool	☐	☐
Passage of mucus alone or with stool	☐	☐
Any problems with certain foods	☐	☐

METABOLIC (ENDOCRINE)	Yes	No
Hormone shots/pills	☐	☐
Dryness of skin	☐	☐
Tendency to feel cold	☐	☐
Easy loss of hair	☐	☐
Dry, brittle finger nails	☐	☐
Shakes or tremors	☐	☐
Bulging eyes	☐	☐
Excessive thirst	☐	☐
Excessive urination	☐	☐
Excessive sweating	☐	☐
Excessive appetite	☐	☐

NEUROLOGIC	Yes	No
Seizures	☐	☐
Convulsions	☐	☐
Fainting spells	☐	☐
Loss of conciousness	☐	☐
Numbness	☐	☐
Muscle weakness	☐	☐
Headaches lasting an abnormal time	☐	☐
Visual disturbances	☐	☐
Ringing in the ear	☐	☐
Loss of balance	☐	☐
Concussion	☐	☐

MUSCULOSKELETAL	Yes	No
Arthritis	☐	☐
Joint pains	☐	☐
Swollen or red joints	☐	☐
Broken bones	☐	☐
Dislocations	☐	☐

DO NOT WRITE BELOW THE LINE

☑ Abnormal only.

PHYSICAL EXAMINATION

Height ______ Weight ______ BP ____________ URINE: Sugar __________ Protein ______________

Gen. Appearance ☐ Normal Hydration and development, alert and oriented and in no acute distress

Skin ☐ Scars _____ Cyanosis _____ Vitiligo _____ Abnormal pigmentation ______________

Head	☐	Normocephalic		
Eyes	☐	Pupils round, equal and react to light and accommodation -- Fundoscopy not done		
Ears	☐	Grossly normal – Hearing good – TM not visualized		
Nose				
Mouth	☐	Normal – Free of lesions and infection – Dentures: U ________ L ______ Partial ______		
Throat				
Neck	☐	Supple	No Thyromegaly	No cervical lymphadenopathy / Neck Veins
Chest	☐	Symetrical	No deformity	Equal Expansion bilat
Breast	☐	No palpable masses	No nipple discharge	No Ax nodes
Heart	☐	Normal Sinus Rhythum	No murmurs of thrills or enlargement	PMI:
Lungs	☐	Clear to P & A	No rales	
Abdomen	☐	Soft	Bowel sounds active	No LKS organomegaly / No Bruit / Scars _____
Ext. Genit.	☐	Normal B-U-S		
Cervix	☐	Normal		
Fundus	☐	NSSP ________ ☐ Enlarged ________ Wks size ☐ Uterine decensus Degree ________		
Adnexa	☐	Normal on left		
	☐	Normal on right		
Vagina	☐	Discharge Normal		Cystocele
	☐	Normal Mucosa		Rectocele
Rectal	☐	Hemorrhoids + ______ - ______		Normal Sphincter tone
R-V	☐	Confirms above findings – U-S Ligs. normal on palpation		
Extremities	☐	Normal, symmetrical, no limitation of motion, no deformities, No jt. swelling or tender		
	☐	No edema or varicosities and Pedal pulses present bilaterally.		
Neurological	☐	Grossly normal function – DTR's normal		

Impression
Rx

Lab Data ☐ Normal ☐ Abnormal Follow up: