FEMALE INTAKE HISTORY

Name:______________________________________ **DOB:**_________________ **Date:**____/____/____

PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLY TO YOU CURRENTLY

1. CONSTITUTIONAL	NO	YES
Chills	()	()
Fatigue	()	()
Fever	()	()
Body Aches	()	()
Night Sweats	()	()
Weight Gain	()	()
Weight Loss	()	()
Other:		

2. HEENT	NO	YES
Ear Drainage	()	()
Ear Pain	()	()
Eye Discharge	()	()
Eye Pain	()	()
Hearing Loss	()	()
Nasal Drainage	()	()
Sinus Pressure	()	()
Sore Throat	()	()
Visual Changes	()	()
Other:		

3. RESPIRATORY	NO	YES
Chronic Cough	()	()
Cough	()	()
Known TB Exposure	()	()
Shortness of Breath	()	()
Wheezing	()	()
Other:		

4. CARDIOVASCULAR	NO	YES
Chest Pain	()	()
Leg Pain with Walking	()	()
Swelling	()	()
Palpitations	()	()
Other:		

5. GASTROINTESTINAL	NO	YES
Abdominal Pain	()	()
Blood in Stools	()	()
Change in Stools	()	()
Constipation	()	()
Diarrhea	()	()
Heartburn	()	()
Loss of Appetite	()	()
Nausea	()	()
Vomiting	()	()
Other:		

6. GENITOURINARY	NO	YES
Painful Urination	()	()
Blood in Urine	()	()
Excessive Urination	()	()
Urinary Frequency	()	()
Urinary Incontinence	()	()
Urinary Retention	()	()
Other:		

7. REPRODUCTIVE	NO	YES
Abnormal Pap	()	()
Breast Discharge	()	()
Breast Lump	()	()
Menstrual Cramps	()	()
Painful Intercourse	()	()
Hot Flashes	()	()
Irregular Periods	()	()
Vaginal Discharge	()	()
Other:		

8. METABOLIC/ENDOCRINE	NO	YES
Brittle Hair	()	()
Brittle Nails	()	()
Cold Intolerance	()	()
Hair Changes	()	()
Heat Intolerance	()	()
Excess Hair Growth	()	()
Excessive Thirst	()	()
Excessive Hunger	()	()
Other:		

9. NEUROLOGICAL	NO	YES
Dizziness	()	()
Extremity Numbness	()	()
Extremity Weakness	()	()
Gait Disturbance	()	()
Headache	()	()
Memory Loss	()	()
Seizures	()	()
Tremors	()	()
Other:		

10. PSYCHIATRIC	NO	YES
Anxiety	()	()
Depression	()	()
Trouble Sleeping	()	()
Other:		

11. INTEGUMENTARY	NO	YES
Contact Allergy	()	()
Hives	()	()
Itching	()	()
Mole Changes	()	()
Rash	()	()
Skin Lesion	()	()
Other:		

12. MUSCULOSKELETAL	NO	YES
Back Pain	()	()
Joint Pain	()	()
Joint Swelling	()	()
Muscle Weakness	()	()
Neck Pain	()	()
Other:		

13. HEMATOLOGIC/LYMPHATIC

Easy Bleeding	()	()
Easy Bruising	()	()
Swollen Lymph Nodes	()	()

Other: [ ]

14. IMMUNOLOGIC

Environmental Allergies	()	()
Food Allergies	()	()
Seasonal Allergies	()	()

Other: [ ]

RACE:______________________________

PRIMARY LANGUAGE SPOKEN:____________________

ETHNICITY: Non-Hispanic, Hispanic, Non-Latino, Latino

SMOKER: () No () Yes Packs per day ______ Years_______

Former Smoker: () No () Yes Packs per day______ Years_____

Preferred form of contact: Phone () Home () Cell () Mail ()

Preferred Pharmacy Information:

Pharmacy #1____

Pharmacy #2____

FAMILY HISTORY

Illness	Yes	Relative	Illness	Yes	Relative
Diabetes			Drinking Problems		
Stroke			Prostate Cancer		
Heart Disease			Colon Cancer		
High Blood Pressure			Breast Cancer		
Other:					

PLEASE LIST ALL MAJOR OPERATIONS

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PLEASE LIST ALL CURRENT MEDICATIONS; NAMES AND DOSAGES

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