Verdugo Internal Medicine
A Medical Group, Inc.
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NAME: _____ **DATE:** _____

FEMALE MEDICAL HISTORY INFORMATION SHEET
INTERIM PHYSICAL

I. Past Medical History

A. Please list any new significant medical illnesses occurring over the last year
_____

B. Please list any surgeries occurring over the last year _____
_____

C. Please list any significant injuries or accidents occurring over the last year
_____

D. Date of Last Menstrual Period _____
Have your periods changed? _____
Methods of birth control:
Vasectomy ____ Oral contraceptives ____ Tubal ligation _____
Diaphragm/condoms _____ Other _____
If you have stopped menstruating, are you taking estrogen? _____
Are you taking calcium? _____ How much per day? _____

E. Please list the medications you are now taking:

Medication	Strength (mg)	Pills Per Day
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____

Please list any new medication allergies _____
_____
_____

II. Social History

A. Has your work or position changed over the last year? _____
If so, what is your new position? _____
Is your work mildly, moderately or highly stressful? _____
Do you enjoy your work? _____
Are there any new significant sources of stresses at home or at work? _____
Do you have any travel history over the past year? _____
Do you have any pets? _____

B. Has your marital status or living arrangement changed over the last year? _____
If so, how? _____
Have you changed your exercise pattern? _____
If so, how? _____
Who could help you in an illness or emergency? _____

C. Have your smoking habits changed? _____
Has your alcohol intake increased, decreased or stayed the same? _____
Any drug abuse? _____
Any special diet? _____

D. Please list any new family history since last Physical: _____
_____
_____

REVIEW OF SYSTEMS

Do you have a significant problem with any of the following symptoms?

Yes	*No*		*Yes*	*No*	
____	____	Fever	____	____	Difficulty Swallowing
____	____	Chills	____	____	Heartburn, nausea, or vomiting
____	____	Night Sweats	____	____	Abdominal Pain
____	____	Weight Loss	____	____	Indigestion
____	____	Weight Gain	____	____	Cramping
____	____	Heat Intolerance	____	____	Diarrhea
____	____	Cold Intolerance	____	____	Constipation
			____	____	Mucous in Stool
____	____	Excessive Bleeding	____	____	Blood in Stool
____	____	Rashes	____	____	Dark or Black Stool
____	____	Itching	____	____	Change in Bowel Habits
____	____	Lumps	____	____	Pain/Discomfort with Urination
____	____	Changes in Moles	____	____	Excessive or Frequent Urination
			____	____	Urge to Urinate
____	____	Headaches	____	____	Loss of Urine with Cough, Laughing or Sneezing
____	____	Change in Vision			
____	____	Blurry or Double Vision	____	____	Other Accidental Loss of Urine or Stool
____	____	Decrease in Hearing			
____	____	Noises in Ears			
____	____	Vertigo			
____	____	Frequent Bloody Noses	____	____	Abnormal vaginal bleeding
____	____	Nasal or Sinus Congestion	____	____	Abnormal vaginal discharge
____	____	Hoarseness	____	____	Pain with intercourse
____	____	Cough	____	____	Vaginal itching
____	____	Sputum	____	____	Breast tenderness
____	____	Bloody Sputum	____	____	Hot flashes
____	____	Shortness of Breath With Minor Exertion	____	____	Pain or Stiffness of Joints (list) _____
____	____	Chest Pressure	____	____	Back Pain
____	____	Chest Pain	____	____	Muscle Pain or Ache
____	____	Shortness of Breath When Lying Flat	____	____	Muscle Weakness
			____	____	Numbness in Arms or Legs
____	____	Unexplained Fatigue			
____	____	Ankle or Foot Swelling	____	____	Anxiety
____	____	Pounding or Skipping Heart	____	____	Depression
____	____	Lightheadedness	____	____	Difficulty Sleeping
____	____	Fainting	____	____	Loss of Appetite
____	____	Pain in Legs on Walking	____	____	Decreased Sex Drive

Any other information you feel relevant:

_____

_____