LITTLETON INTERNAL MEDICINE
ASSOCIATES

Specialists in Prevention Diagnosis and Treatment of Adult Illness

FEMALE HISTORY

(Returning patients may update as needed since last complete exam)

Exam Date: _____
Name: _____ Date of Birth: _____

CHECK ONE:
□ Married □ Single □ Widowed
□ Divorced □ Living Together

Occupation/Employer: _____ Highest Level of Education: _____

HOSPITALIZATIONS IF YOU HAVE BEEN IN THE HOSPITAL OVERNIGHT | STATE THE YEAR | ILLNESS/OPERATION (DOES NOT INCLUDE NORMAL PREGNANCIES)

YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

MEDICAL HISTORY MARK **C** FOR CURRENT PROBLEM; MARK **X** AND INDICATE AGE WHEN YOU HAD ANY OF THE FOLLOWING SYMPTOMS OR PROCEDURES.

LIST MAIN PROBLEMS: 1) _____ 2) _____ 3) _____

___ Decreased Hearing
___ Ringing in Ear
___ Ear Infections – Frequent
___ Dizzy Spells
___ Failing Visions
___ Double or Blurred Vision
___ Eye Pain ___ Eye Disease
___ Eye Infections – Frequent
___ Nose Bleeds – Recurring
___ Sinus Trouble
___ Frequent Sore Throats
___ Allergies/Hay Fever
___ Hoarseness – Prolonged
___ Pneumonia ___ Lung Disease
___ Bronchitis/Chronic Cough
___ Asthma/Wheezing
___ Shortness of Breath
___ On Exertion ___ Lying Flat
___ High Cholesterol
___ Chest pain ___ Angina
___ High Blood Pressure
___ Heart Murmur ___ Heart Attack
___ Palpitations
___ Heart Valve Disease
___ Irregular Pulse
___ Swollen Ankles
___ Fainting Spells

___ Leg Pain when Walking
___ Varicose Veins/Phlebitis
___ Loss of Appetite – Recent
___ Difficulty Swallowing
___ Indigestion/Heartburn
___ Persistent Nausea/Vomiting
___ Peptic Ulcers
___ Abdominal Pain – Chronic
___ Change in Bowel Habits-Recent
___ Diarrhea
___ Constipation
___ Diverticulosis
___ Bloody or Tarry Stools
___ Hemorrhoids
___ Gall Bladder Trouble
___ Jaundice/Hepatitis
___ Hernia
___ Urine Infections – Frequent
___ Painful Urination
___ Blood in Urine
___ Overnight Urination (2+)
___ Control in Urination
___ Decrease in Force Urination
___ Kidney Stones
___ Other Kidney/Bladder Infections
___ Venereal Disease
___ Urethral Discharge

___ Bleeding Disorder
___ Chronic Fatigue
___ Weight Loss – Recent
___ Anemia ___ Bruise Easily
___ Cancer
___ Diabetes
___ Thyroid Disease
___ Convulsions/Seizures
___ Stroke
___ Tremor/Hands Shaking
___ Muscle Weakness
___ Neurological
___ Numbness/Tingling Sensations
___ Headaches – Frequent
___ Migraines
___ Arthritis/Rheumatism
___ Back Pain – Recurring
___ Bone Fracture/Joint Injury
___ Gout ___ Osteoporosis
___ Foot Pain ___ Cold Numb Feet
___ Rashes ___ Hives
___ Psoriasis ___ Eczema
___ Sleeping – Difficulty
___ Nervousness ___ Depression
___ Memory Loss
___ Moodiness – Excessive
___ Phobias

___ Mental Illness
___ Alcoholism
___ Blood Transfusion
___ Chicken Pox
___ Polio
___ Measles
___ Mumps
___ German Measles
___ Tuberculosis
___ Rheumatic Fever
___ Scarlet Fever

Other Symptoms of Disease
_____
_____
_____

FAMILY HISTORY IF ANY BLOOD RELATIVE HAS SUFFERED ANY OF THE FOLLOWING, INDICATE WHICH RELATIVE.

□ Tuberculosis _____
□ Stroke _____
□ Migraine_____
□ Mental Illness _____
□ Allergy _____
□ Hypertension _____
□ Epilepsy _____

□ Diabetes _____
□ Cancer _____
□ Glaucoma _____
□ Heart Attack _____
□ Arthritis/Gout _____
□ Lung Disease _____
□ Kidney Disease _____

□ Other _____
_____
_____

DATE OF LAST MENSTRUAL PERIOD
_____
ARE YOU USING BIRTH CONTROL?
□ YES □ NO
____ NUMBER OF PREGNANCIES
____ NUMBER OF LIVE BIRTHS
____ NUMBER OF ABORTIONS
____ NUMBER OF MISCARRIAGES
_____
DATE OF LAST:
Pap Test _____ □ NORM □ ABN
Breast Exam _____ □ NORM □ ABN
Mammogram _____ □ NORM □ ABN
ARE YOU DOING SELF BREAST EXAMS?
□ YES □ NO ____ per Month
OTHER _____

DO YOU NOW OR HAVE EVER

CURRENT SMOKER □ YES □ NO
FORMER SMOKER QUIT DATE _____
DRINK ALCOHOL □ YES □ NO DRINKS/WK _____
DRINK COFFEE/TEA □ YES □ NO CUPS/DAY _____
USE(D) STREET/ILLEGAL DRUGS □ YES □ NO
TYPE: _____

DRUG ALLERGIES

DRUG	REACTION

LIST OF ALL MEDICATIONS YOU NOW TAKE

MEDICATION	DOSE	DAY

HEALTH HABITS

DO YOU EXERCISE? □ YES □ NO
TYPE: _____
DURATION: _____ FREQUENCY: _____
OTHER: _____
USE SUNSCREEN? □ YES □ NO
EXAMINE SKIN FOR CHANGES? □ YES □ NO
USE SEAT BELTS? □ YES □ NO

THE LAST TIME YOU HAD

FLU SHOT _____ TETANUS SHOT _____
HEPATITIS VACC _____ PNEUMONIA SHOT _____
RECTAL EXAM _____ T.B. TEST _____
STOOL BLOOD TEST _____ SIGMOID EXAM _____
EYE EXAM _____ DENTAL EXAM _____
CHOLESTEROL TEST _____ RESULTS _____
_____

ARE YOU HAVING ANY SYMPTOMS OR PROBLEMS THAT YOU WOULD LIKE TO DISCUSS? *PLEASE LIST THEM*

DO YOU HAVE ANY OTHER MEDICAL PROBLEMS FOR WHICH YOU HAVE BEEN SEEING A DOCTOR ON A REGULAR BASIS? *PLEASE LIST THEM*

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