

History Form, Part II

Patient Name: _____

Social / Lifestyle

Marital status: _____ Sexual orientation: _____ Active: Y N

Highest grade, or degree, completed: _____ Occupation: _____

Is your work satisfying? _____ Stressful? _____

Which people can you count on for support in times of need? _____

Was your childhood pleasant, or difficult? _____

Any physical or sexual abuse, past or present? _____

Have you had problems with alcohol or substance abuse? _____

Do you engage in prayer, meditation, yoga, or other forms of stress management? _____

What do you do for fun? _____

Do you follow any dietary guidelines? _____

What types of exercise do you do, and how often? _____

Review of Systems: Please CIRCLE any that apply in the last 6 months.

- Weight change Night sweats Hot flashes Unusual fatigue Hair loss Headaches
- Painful intercourse Chronic vaginal discharge Vaginal dryness Loss of sex drive
- Mood swings Anxiety attacks Irritability Breast tenderness Nipple discharge
- Memory/concentration difficulty Dizziness/Fainting Numbness Clumsiness
- Increase of facial/body hair Acne Sleep disturbance Aching joints
- Intolerance to heat or cold Vision change Hearing problems Earaches Sinus problems
- Dental problems Easy bruising Swollen glands Rash Eczema Change in mole
- Chest pain Irregular heartbeat Severe shortness of breath Chronic cough/wheeze
- Frequent diarrhea/constipation Gas/bloating Blood in stool Loss of gas/stool control
- Blood in urine Painful urination Urine leakage w/cough or sneeze Frequent infection

What else about you is important that is not covered by these forms? _____
