FAMILY PRACTICE PHYSICIANS

INTERVAL MEDICAL HISTORY

Medical Events:

Allergies:

Foreign Travel:

Alcohol:

Tobacco Use:

Name_____

Date_____

REVIEW OF SYMPTOMS

PLACE A CHECK (✔) in front of any of the following body parts or symptoms that are problems for you. Circle the specific problems you are most concerned about.

(A)
- ☐ Rashes, color change
- ☐ Itching, bruising
- ☐ Warts, moles, lumps, hives
- ☐ Skin trouble, eczema
- ☐ Excessive sweating
- ☐ Bleeding, anemia
- ☐ Gland swelling

(B)
- ☐ Head injury, concussion
- ☐ Headaches, migraine
- ☐ Dizziness, fainting
- ☐ Ear trouble, infection
- ☐ Hearing loss, noises
- ☐ Vision loss, double vision
- ☐ Glasses, difficulty reading
- ☐ Nosebleeds, stuffy nose
- ☐ Sinus trouble, hayfever
- ☐ Sore throats, hoarseness
- ☐ Dental problems, gums
- ☐ Goiter, thyroid problem

(C)
- ☐ Enlargement, painful breasts
- ☐ Lumps, discharge from breasts

(D)
- ☐ Shortness of breath
- ☐ Cough, chest colds
- ☐ Bringing up sputum or blood
- ☐ Wheezing, asthma
- ☐ Chest pain, pleurisy
- ☐ Exposure to tuberculosis
- ☐ Fevers, sweats, chills

(E)
- ☐ Chest pain, tightness, pressure
- ☐ Fast or irregular heartbeat
- ☐ Trouble breathing when lying down
- ☐ Waking short of breath
- ☐ Swelling of feet and ankles
- ☐ Previous heart trouble, murmurs
- ☐ High blood pressure
- ☐ Poor circulation, varicose veins
- ☐ Blood clots

(F)
- ☐ Pain or burning on urination
- ☐ Trouble starting or stopping urination
- ☐ Blood or pus in urine
- ☐ Frequent urinating
- ☐ Sores or discharge

(G)
- ☐ Trouble swallowing
- ☐ Poor appetite
- ☐ Gas, cramps and pains
- ☐ Heartburn, indigestion
- ☐ Nausea, vomiting
- ☐ Constipation, diarrhea
- ☐ Blood in stool, hemorrhoids
- ☐ Yellow jaundice, hernia

(H)
- ☐ Pains in joints, arthritis
- ☐ Back pain, neck pain
- ☐ Swollen or red joints, stiffness

(I)
- ☐ Convulsions, fits, spells
- ☐ Shaking, weakness, tremor
- ☐ Numbness, tingling, paralysis
- ☐ Difficulty walking, coordination
- ☐ Depression, anxiety, panic
- ☐ Poor sleeping
- ☐ Nervousness, tension
- ☐ Trouble thinking, remembering
- ☐ Crying, upset, worrying
- ☐ Sexual problems
- ☐ Birth control - type_____

(J)
- ☐ Irregular or frequent periods
- ☐ Excessive flow or spotting
- ☐ Painful periods
- ☐ Vaginal discharge or itching
- ☐ Hot flashes or vaginal dryness

Number of pregnancies_____
Number of miscarriages_____
Number of abortions_____
Number of living children_____
Date of last period_____
Date of last cancer smear (PAP)
_____
Blood type_____

(K)
- ☐ Blood transfusions
- ☐ Used IV drugs

(L)
- ☐ Do you ever feel unsafe at home with your partner
- ☐ Are you a victim of domestic violence
- ☐ Have you ever been hit by your partner

- ☐ Other_____

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PRINTED IN JUNEAU BY ALASKA LITHO, INC.