The Jackson Clinic

Patient Label

For office use only:

Height ________ Weight ________ Temp ________ HR ________RR _________ BP _______

Age _______ Last Menstrual Period __________________ Primary Care Physician ___________________________

Reason for Visit: Physical Problem Follow-up Referring Physician ___________________

<u>If here for a physical, skip to section 2.</u>

<u>Section 1</u>

1) Describe the problem, and how long you have had it. ____

____

2) If pain, describe the pain. ____

3) Location of the pain. ____

4) On a scale of 1-10, how bad is the pain? (1=None, 10=Most Severe) ____

5) Does the pain stay in one place or move to other places? ____

6) Do you take medication for the problem? Yes No If yes, what do you take? __________________________

7) What brings you relief? ____

<u>Section 2</u>

- Con Recent Fever Unexplained Weight Loss Unexplained Weight Gain Loss of Appetite
- GI Recent Nausea Diarrhea Pain Vomiting Constipation Bloating Dark Stools
  Blood in stools
- GU Recent Pain with Urination Urge to Urinate Frequent Urination Blood in Urine
  Flank Pain Loss of Control of Urine Frequent Urination in the night
- GY
  1) Are you experiencing any vaginal discharge? ____
  2) Are you still having periods? Yes No **<u>If no, skip to #10</u>**
  3) Are your periods regular? Yes No
  4) When was your last menstrual period? __________________________ was it normal? Yes No
  5) What is the average number of days from the start of one period to the start of another? ___________________
  6) How many days do your periods normally last? ________ Is your period: Heavy Moderate Light
  7) Do you experience cramps during your period? _________Are the cramps: Mild Moderate Severe
  8) Do you take medicine for your cramps? Yes No
  9) Do you bleed between periods? Yes No
  10) Check the appropriate box. Hysterectomy Menopausal at what age? ______________________
  11) Are you on hormone treatment? Yes No If yes, what kind? _________________________
- Breast Breast Masses Discharge Skin Changes
- Skin Recent Rashes Bruising Change in Moles New Lesions
- Psy Recent Nervousness Depressed Mood Anxiety Menopausal Symptoms
- Resp Recent Cough Shortness of Breath Pain with Deep Breaths
- CV Recent Chest Pain Irregular Heartbeat Rapid or Slow Heartbeat Swelling in Legs
  Shortness of Breath while lying down
- Neur Recent Headaches Numbness Weakness Unexplained Tingling

• Past Medical History (Please check all that apply)

Arthritis	Heart Disease	Osteoporosis
Asthma	High Cholesterol	Psychiatric
Cancer	High Blood Pressure	Seizure Disorder
Type? ____________________	Kidney Disease	Spastic Colon
Chronic Lung Disease	Liver Disease	Stomach Problems
Diabetes	Neurological Problems	Thyroid Disease

● Past Surgical History (Please check all that apply)

Appendectomy
Bladder Surgery
Breast Biopsy
Breast Removed
C-section
D & C
Endometrial Ablation
Gall Bladder

Hernia Repair
Hysterectomy (Abdominal) (Vaginal)
Laparoscopy (reason) ____________________
Ovary or ovaries removed (Both Right only Left only)
Thyroidectomy (partial)
Tonsillectomy
Tubal Ligation
Other __________________________________

Family History (Please check all that apply)

	Father	Mother	Brother (s)	Sister (s)	Children
Breast Cancer					
Colon Cancer					
Ovarian Cancer					
Uterine Cancer					
Diabetes					
High Blood Pressure					
Heart Disease					
Osteoporosis					
Other					

Pregnancy History

Number of times pregnant __________
Births _______ Miscarriage ________ Abortion ________ Living Children ________
Vaginal Birth C-section Both

Pap Smear History

Date of last Pap Smear ______________________________
History of abnormal Pap smear? Yes No
If yes, treatment _____________________________ Date of treatment _________________________

Have you ever been treated for a sexually transmitted disease?
If yes: Gonorrhea Syphilis Herpes Chlamydia HIV Condyloma (warts)
Are you currently sexually active? Yes No
Are you experiencing any sexual problems? Yes No If yes, explain ________________________

Social History

Marital Status: Divorced Married Single Widowed

Current Method of Birth Control

Birth Control Pills
Condoms
Depo Provera
Does Not Apply
None

Nuva Ring
Tubal Ligation
Vasectomy
Other (______________________)

Do you work? In the home Outside the home If outside, where? _________________________________
Tobacco use: No Yes If yes, how many packs per day? ______ For how many years_________
Alcohol use: No Yes If yes, how much? Minimal Moderate Heavy
Street drugs: No Yes If yes, when and what type? ____________________________________

Current Procedures Due:
Date of last mammogram ___________________________________
Date of last Dexascan for osteoporosis ________________________
Date of last colonoscopy ___________________________________
Date of last lipid profile ____________________________________