

INTERVAL HISTORY

Today's Date: _____

Name: _____ Birthdate: _____ Marital Status: _____ Age: _____

PLEASE HELP KEEP YOUR RECORDS UP TO DATE BY ANSWERING THE FOLLOWING QUESTIONS:

Who is your primary care physician? _____ Please list any other physicians that you see and why: _____

How tall are you?: _____ Are you here today for a routine exam? _____ or problem? _____

If you have a problem, please describe it:

Do you smoke? _____ How much? _____ Have you changed any habits (smoking, drinking, drug use) or job since your last visit? _____ Describe: _____

Do you use Caffeine? _____ How much?: _____ per day/week?

Do you exercise?: _____ Type and frequency: _____

How many pregnancies have you had? _____ How many births? _____ Miscarriages? _____

What are you using for birth control? _____ When was your last period? _____

Was it normal? _____ Interval between periods? _____ #Days Bleeding: _____

Are you sexually active? _____ When was your last pap? _____ Mammogram? _____

Are you allergic to any medications? Please list: _____

What medications are you currently taking and how often? _____

Have you had any serious illnesses, operations, injuries, or have you been hospitalized since your last appointment in our office (please describe): _____

Have you discovered any additional information about your family medical history that we should be aware of? _____

Anything else we need to know: _____