Health Review Form - Female

Name ______________________

Health Habits

Do you drink alcohol?	Yes	No	If yes, how much each day?	_______
Do you smoke cigarettes?	Yes	No	If yes, how many packs per day?	_______
Do you smoke a pipe or cigars?	Yes	No	If yes, how many per day?	_______
Do you drink coffee?	Yes	No	If yes, how many cups each day?	_______
Do you drink tea?	Yes	No	If yes, how many cups each day?	_______
Do you use other drugs?	Yes	No	If yes, which?_________________________	

How many hours do you sleep during an average night? _______

Who lives in your home with you?

Are you working? If so, where?

Health Review

Do you have any of the following? Check all that apply.

GENERAL
_____ Unintentional weight gain or loss
_____ Fever
_____ Fatigue
_____ Night sweats
_____ Loss of appetite
_____ Difficulty sleeping

EYE
_____ Blurry or double vision
_____ Loss of vision

EAR, NOSE, and THROAT
_____ Hearing problems
_____ Ringing in your ears
_____ Sinus problems
_____ Difficulty swallowing
_____ Neck swelling
_____ Hoarseness

HEART
_____ Chest pain
_____ Rapid or irregular heart beat
_____ Passing out or loss of consciousness
_____ Swollen feet

LUNGS
_____ Shortness of breath
_____ Cough
_____ Wheezing
_____ Coughing up blood

GASTROINTESTINAL
_____ Hemorrhoids
_____ Nausea or vomiting
_____ Heartburn
_____ Diarrhea
_____ Constipation
_____ Blood in stool
_____ Black tarry stool
_____ Change in bowel habits

MUSCULOSKELETAL
_____ Joint pain
_____ Joint swelling

URINARY
_____ Incontinence
_____ Urgency
_____ Burning on urination
_____ Difficulty urinating
_____ Blood or mucus in urine
_____ Frequent urination

SKIN
_____ Moles that you are concerned about
_____ Rash
_____ Itching

NEUROLOGICAL
_____ Dizziness
_____ Numbness
_____ Weakness
_____ Tremor
_____ Unsteady while walking

ENDOCRINE
_____ Swelling of hands or fingers
_____ Excessive thirst
_____ Large amount of urine

LYMPHATIC/HEMATOLOGICAL
_____ Swollen glands
_____ Bruise easily
_____ Sores that do not heal

PSYCHOLOGICAL
_____ Anxiety
_____ Depression
_____ Panic attacks

ALLERGIC/IMMUNOLOGIC
_____ Sneezing
_____ Watery eyes

BREASTS
_____ Swelling
_____ Masses
_____ Discharge

SEXUAL HISTORY
_____ 5 or more sexual partners (during lifetime)
_____ Sexual activity before age 16