



PAUL B. MURPHREE, M.D.  
MICHAEL T. FITZPATRICK, M.D.  
SUSAN E. ORTH, M.D.  
MARK E. MAUNDER, M.D.  
ALISON A. RODRIGUEZ, M.D.  
STEPHANIE S. MICHEL, M.D.

*Please fill out this form completely. If you are uncomfortable answering any questions, leave them blank. You can discuss them with your doctor or nurse.*

Print Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_

Preferred Pharmacy and Address \_\_\_\_\_

• What is the reason for your visit today? \_\_\_\_\_  
\_\_\_\_\_

• Are you currently pregnant? Y N Maybe  
• Please list the number and outcome of your previous pregnancies: \_\_\_\_\_  
\_\_\_\_\_

• When was the first day of your last menstrual period? \_\_\_\_\_  
• Please indicate your present method of **birth control**: \_\_\_\_\_  
• How long is it between the start of one period and the start of the next? \_\_\_\_\_ Length of menses \_\_\_\_\_  
• The number and size of tampons and/or pads that you use on your "heaviest" day: \_\_\_ tampons \_\_\_ pads  
• Have you noticed anything different about your periods? \_\_\_\_\_  
• Have you had any spotting and/or bleeding between periods? Y N

• Are you sexually active? Y N For teens: age of first intercourse: \_\_\_\_\_  
• Have you ever had a **sexually transmitted disease**? Y N  
• Have you ever had an **abnormal pap**? Y N

• Please list any ongoing **medical illnesses**: \_\_\_\_\_

• Please list any **surgeries**: \_\_\_\_\_  
\_\_\_\_\_

• List any medicine or food **allergies**: \_\_\_\_\_  
• List your current **medications** and doses: \_\_\_\_\_

• List any current **non-prescription medications** (including herbal medications): \_\_\_\_\_

• Do you drink **alcohol**? Y N Type \_\_\_\_\_ Daily amount \_\_\_\_\_  
• Do you **smoke**? Y N Daily amount \_\_\_\_\_  
• Do you use any **drugs**? Y N Type \_\_\_\_\_ Daily amount \_\_\_\_\_

• Marriage status \_\_\_\_\_ • Occupation \_\_\_\_\_

• What medical problems run in your family? \_\_\_\_\_  
Does anyone have **breast, ovarian or colon cancer**? Who and what age? \_\_\_\_\_

**REVIEW OF SYSTEMS**

(PLEASE INDICATE IF ANY OF THE FOLLOWING SYMPTOMS APPLY TO YOU NOW.)

CONSTITUTIONAL	PHYSICIAN NOTES	GENITOURINARY	PHYSICIAN NOTES
<input type="checkbox"/> WEIGHT LOSS		<input type="checkbox"/> BLOOD IN URINE	
<input type="checkbox"/> WEIGHT GAIN		<input type="checkbox"/> PAIN WITH URINATION	
<input type="checkbox"/> FEVER		<input type="checkbox"/> STRONG URGENCY TO URINATE	
<input type="checkbox"/> FATIGUE		<input type="checkbox"/> FREQUENT URINATION	
<input type="checkbox"/> CHANGES IN HEIGHT		<input type="checkbox"/> INCOMPLETE EMPTYING	
<b>EYES</b>		<input type="checkbox"/> INVOLUNTARY/UNINTENDED URINE LOSS	
<input type="checkbox"/> DOUBLE VISION		<input type="checkbox"/> PAINFUL INTERCOURSE	
<input type="checkbox"/> SPOTS BEFORE EYES		<input type="checkbox"/> INFERTILITY	
<input type="checkbox"/> VISION CHANGES		<input type="checkbox"/> DES EXPOSURE	
<input type="checkbox"/> GLASSES/CONTACTS		<input type="checkbox"/> ABNORMAL VAGINAL DISCHARGE	
<b>EAR, NOSE, AND THROAT</b>		<b>SKIN</b>	
<input type="checkbox"/> EARACHES		<input type="checkbox"/> MOLES	
<input type="checkbox"/> RINGING IN EARS		<input type="checkbox"/> SORES	
<input type="checkbox"/> HEARING PROBLEMS		<input type="checkbox"/> DRY SKIN	
<input type="checkbox"/> SINUS PROBLEMS		<input type="checkbox"/> RASH	
<input type="checkbox"/> SORE THROAT		<b>BREASTS</b>	
<input type="checkbox"/> MOUTH SORES		<input type="checkbox"/> PAIN IN BREAST	
<input type="checkbox"/> DENTAL PROBLEMS		<input type="checkbox"/> NIPPLE DISCHARGE	
<b>CARDIOVASCULAR</b>		<input type="checkbox"/> LUMPS	
<input type="checkbox"/> PAINFUL BREATHING		<b>NEUROLOGIC</b>	
<input type="checkbox"/> CHEST PAIN OR PRESSURE		<input type="checkbox"/> DIZZINESS	
<input type="checkbox"/> DIFFICULTY BREATHING		<input type="checkbox"/> FAINTING	
<input type="checkbox"/> SWELLING OF LEGS		<input type="checkbox"/> NUMBNESS	
<input type="checkbox"/> RAPID OR IRREGULAR HEARTBEAT		<input type="checkbox"/> TROUBLE WALKING	
<b>RESPIRATORY</b>		<input type="checkbox"/> SEVERE MEMORY PROBLEMS	
<input type="checkbox"/> WHEEZING		<input type="checkbox"/> FREQUENT OR SEVERE HEADACHES	
<input type="checkbox"/> SPITTING UP BLOOD		<b>PSYCHIATRIC</b>	
<input type="checkbox"/> SHORTNESS OF BREATH		<input type="checkbox"/> DEPRESSION OR FREQUENT CRYING	
<input type="checkbox"/> CHRONIC COUGH		<input type="checkbox"/> SEVERE ANXIETY	
<b>GASTROINTESTINAL</b>		<b>ENDOCRINE</b>	
<input type="checkbox"/> FREQUENT DIARRHEA		<input type="checkbox"/> HAIR LOSS	
<input type="checkbox"/> BLOODY STOOL		<input type="checkbox"/> HEAT OR COLD INTOLERANCE	
<input type="checkbox"/> NAUSEA/VOMITING/INDIGESTION		<input type="checkbox"/> ABNORMAL THIRST	
<input type="checkbox"/> CONSTIPATION		<input type="checkbox"/> HOT FLASHES	
<input type="checkbox"/> INVOLUNTARY LOSS OF GAS/STOOL		<b>HEMATOLOGIC/LYMPHATIC</b>	
<b>MUSCULOSKELETAL</b>		<input type="checkbox"/> FREQUENT BRUISES	
<input type="checkbox"/> MUSCLE WEAKNESS		<input type="checkbox"/> CUTS DO NOT STOP BLEEDING	
<input type="checkbox"/> MUSCLE OR JOINT PAIN		<input type="checkbox"/> ENLARGED LYMPH NODES OR GLANDS	

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