Advanced Menstrual Care Center

Control your period.
Improve your life!

Name:_____ **Chart #:**_____ **Date:**_____

Please answer the following question about any changes to your health, or that of your family.

What concerns or problems do you have for today's visit?_____

_____

Primary Care Provider (Name, Address & Phone):_____

_____

List other doctors (and specialty):_____

_____

Since your last visit:

	Yes	No
Have you had any HOSPITAL ADMISSION?		
Have you had any SURGERY of any type?		
Do you have any new ALLERGIES?		
Have you started any new MEDICATIONS or SUPPLEMENTS?		
Any major health problems in your family members (e.g. cancer, diabetes, stroke, heart disease, blood clots, etc)?		
Any tests, X-rays, biopsies or other tests since your last visit?		

Activity	Yes	No	Comments
Drink alcohol?			
Use tobacco?			
Use street drugs?			
Exercise?			
Family activities?			
Hobbies?			
Religious/spiritual beliefs?			

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Name:_____ **Chart #:**_____ **Date:**_____

Review of Systems

This questionnaire searches for subtle signs of problems that may require further evaluation. Please note that a healthy person will have many of these symptoms intermittently. Those symptoms that are persistent, recurrent or severe are the most important in a patient's history.

Body System	No Concerns ☑	Symptoms (Please Circle All That Apply)	Comments
General Health		Excess fatigue | Unexplained weight loss | Excess weight gain | Loss of appetite | Fever | Night sweats | Insomnia	
Heart & Vessels		Palpitations | Irregular heart beat | Racing heart | Chest pain | Persistent swelling of legs | Pain in legs when walking | Sleeping on 2 or more pillows | Frequent dizziness | Cold hands or feet	
Lungs & Airways		Shortness of breath | Wheezing | Difficulty catching breath | Frequent, chronic coughing | Coughing up blood | Coughing up sputum | Pain on breathing | Prior TB | TB exposure | Oxygen therapy | Abnormal X-rays	
Ears, Nose, Throat		Difficulty hearing | Ear pain | Ear discharge | Chronic runny nose | Post-nasal drip | Chronic nasal congestion | Sinus pain | Ringing in ears | Nosebleeds | Sore throat | Hoarseness | Facial pain or numbness | Eye pain | Tunnel vision | Floaters | Bleeding gums | Dental problems | Dentures | Partial plates | Contacts | Other implants of any type	
Intestinal Tract		Heartburn | Constipation | Frequent diarrhea | Black stools | Bloody stools | Frequent vomiting | Bloody vomit | Abdominal pain | Leaking stools | Painful bowel movements | Change in bowel movements | Jaundice | Loss of appetite | Loss of taste	
Kidneys & Bladder		Painful urination | Leaking urine | Bloody urine | Prior kidney or bladder infections | Painful urination | Urinary frequency | Urgency of urine | Discolored urine	
Muscle & Bones		Joint pain | Joint swelling | Difficulty moving joints | Aching muscles | Knots on skin, joints or muscles	
Skin, Hair & Breasts		Persistent rash | Chronic itching | Changing moles | Chronic ulcers | Draining ulcers | Poor wound healing | Hair loss | Excessive hairiness |	
Brain & Nerves		Frequent headaches | Blurred vision | Double vision | Loss of vision | Difficulty walking | Difficulty with balance | Falling | Dizziness | Tremor | Numbness or loss of sensation | Weakness of a body part or area |	
Glands		Intolerance to heat or cold | Excess hunger | Excess thirst | Menstrual irregularities	
Blood & Lymph		Easy bruising or bleeding | Difficulty stopping bleeding | Anemia | Swollen lymph glands | Prior blood clots to lungs or other areas	
Immune System		Seasonal allergies | Frequent infections | History of or risk for HIV | Severe allergic reactions	
Psychiatric		Current or prior depression | Prior psychiatric diagnosis or treatment | Suicidal thoughts | Homicidal thoughts | Mood swings | Compulsions | Anxiety | Obsessive thoughts | Hallucinations | Memory loss	
Women's Health		Painful sex | Painful periods | Menstrual clots | Missing periods | Heavy periods | Infertility | Breast pain | Breast lump | Breast discharge	

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