

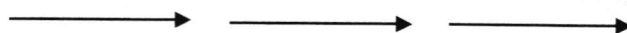
## INTERVAL HISTORY

**Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_      **Name:** \_\_\_\_\_  
**DOB:** \_\_\_\_\_      **Age:** \_\_\_\_\_      **Marital Status:** \_\_\_\_\_  
**Home Phone:** \_\_\_\_\_      **Cell Phone:** \_\_\_\_\_

**\*\*PLEASE HELP KEEP OUR OFFICE UP TO DATE BY ANSWERING THE FOLLOWING QUESTIONS\*\***

1. LOCAL PHARMACY, NAME & PHONE: \_\_\_\_\_
2. MAIL IN PHARMACY, NAME & PHONE: \_\_\_\_\_
3. DATE OF LAST MENSTRUAL CYCLE: \_\_\_\_/\_\_\_\_/\_\_\_\_      WAS CYCLE NORMAL?      YES / NO
4. WHAT WAS THE DATE OF YOUR LAST MAMMOGRAM? \_\_\_\_/\_\_\_\_/\_\_\_\_
5. WHERE DID YOU HAVE YOUR LAST MAMMOGRAM? \_\_\_\_\_
6. WHO IS YOUR PRIMARY CARE PHYSICIAN? \_\_\_\_\_
7. DO YOU SEE ANY OTHER PHYSICIANS?      YES / NO
  - a. IF YES, PLEASE LIST: \_\_\_\_\_
8. HAVE YOU HAD ANY SERIOUS ILLNESSES, OPERATIONS, INJURIES, OR HOSPITALIZED SINCE YOUR LAST VISIT IN OUR OFFICE?      YES / NO
  - a. IF YES, PLEASE EXPLAIN: \_\_\_\_\_
9. HAS ANY FAMILY HEALTH HISTORY CHANGED SINCE YOUR LAST VISIT IN OUR OFFICE?  
YES / NO
  - a. IF YES, PLEASE EXPLAIN: \_\_\_\_\_
10. HAVE YOUR MEDICATIONS CHANGED SINCE YOUR LAST VISIT IN OUR OFFICE?      YES / NO
  - a. IF YES, PLEASE EXPLAIN: \_\_\_\_\_
11. HAVE YOU CHANGED ANY HABITS (SMOKING, DRINKING, OR DRUG USE) OR OCCUPATION SINCE YOUR LAST VISIT IN OUR OFFICE?      YES / NO
  - a. IF YES, PLEASE EXPLAIN: \_\_\_\_\_

**PLEASE CONTINUE ON BACK SIDE**



## INTERVAL HISTORY

If you **are** experiencing any of the following symptoms, please mark those that apply to you. If none, check here.

Constitutional		Gynecological	
	Fever		Bleeding or pain with intercourse
	Chills		Unusual vaginal discharge or odor
	Sweats		Vulvar or vaginal itching or burning
	Weight change – gain/loss		Pelvic pain
	Weakness		
	Fatigue	Urinary	
			Painful urination
Eyes			Frequent urination
	Change in vision		Urinary urgency
			Blood in urine
Ears, Nose, Mouth, Throat			Urinary incontinence
	Change in hearing		Getting up at night to urinate
	Nose bleeds		
	Sore throat	Musculoskeletal	
	Dry mouth		Back pain
			Weakness
Cardiovascular			Joint pain, stiffness, swelling
	Dizziness		
	Shortness of breath	Integumentary/Breast	
	Chest pain		Nodules
	Loss of consciousness		Change in moles, freckles
	Palpitations		Change in hair – growth, loss, texture
			Breast lumps
Respiratory			Breast nipple discharge
	Chest pain		Breast pain
	Cough – productive/ dry		
	Shortness of breath	Neurological/Psychiatric	
	Wheezing		Memory change
			Depression
Gastrointestinal			Anxiety
	Abdominal pain		Mood swings
	Nausea		Numbness or tingling
	Vomiting		
	Change in bowel habits	Endocrine	
	Change in appetite		Weight change
	Dark or bloody stool		Excessive thirst, urination
	Indigestion		Tremor
	Constipation or diarrhea		Cold or heat intolerance
Hematologic/Lymphatic			
	Swollen lymph glands		
	Easy bruisability		