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
	Fever
	Chills
	Sweats
	Weight change – gain/loss
	Weakness
	Fatigue

	Eyes
	Change in vision

	Ears, Nose, Mouth, Throat
	Change in hearing
	Nose bleeds
	Sore throat
	Dry mouth

	Cardiovascular
	Dizziness
	Shortness of breath
	Chest pain
	Loss of consciousness
	Palpitations

	Respiratory
	Chest pain
	Cough – productive/ dry
	Shortness of breath
	Wheezing

	Gastrointestinal
	Abdominal pain
	Nausea
	Vomiting
	Change in bowel habits
	Change in appetite
	Dark or bloody stool
	Indigestion
	Constipation or diarrhea

	Hematologic/Lymphatic
	Swollen lymph glands
	Easy brusability

	Gynecological
	Bleeding or pain with intercourse
	Unusual vaginal discharge or odor
	Vulvar or vaginal itching or burning
	Pelvic pain

	Urinary
	Painful urination
	Frequent urination
	Urinary urgency
	Blood in urine
	Urinary incontinence
	Getting up at night to urinate

	Musculoskeletal
	Back pain
	Weakness
	Joint pain, stiffness, swelling

	Intergumentary/Breast
	Nodules
	Change in moles, freckles
	Change in hair – growth, loss, texture
	Breast lumps
	Breast nipple discharge
	Breast pain

	Neurological/Psychiatric
	Memory change
	Depression
	Anxiety
	Mood swings
	Numbness or tingling

	Endocrine
	Weight change
	Excessive thirst, urination
	Tremor
	Cold or heat intolerance