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INTERVAL HISTORY FORM

1. NAME: _____ AGE: _____ MARITAL STATUS: S M W D
2. OCCUPATION: _____
3. HAVE YOU HAD SINCE YOUR LAST EXAM ANY OF THE FOLLOWING:
   HOSPITAL ADMISSIONS (with dates): _____
   OPERATIONS (with dates): _____
   ILLNESS/INJURY: _____
   OTHER: _____
4. HAS THERE BEEN ANY CHANGE IN YOUR FAMILY HISTORY SINCE YOUR LAST VISIT? IF SO, PLEASE NOTE BELOW:
   _____
5. CHECK THE DISEASES AGAINST WHICH YOU HAVE BEEN IMMUNIZED SINCE LAST EXAM:
   Flu ____ Pneumovax ____ Measles ____ Polio ____ Hepatitis B ____ Tetanus ____
6. ARE YOU ALLERGIC TO ANY DRUGS, FOODS, OR OTHER PRODUCTS? PLEASE LIST: _____
   _____
7. MEDICATIONS: List any prescription medicines you now use or have recently used: _____
   _____
   List any non-prescription products you now use or have recently used: _____
   _____
   Have you ever taken Cortisone-type drugs? Birth Control Pills? Hormones?
8. SOCIAL HISTORY:

Do you smoke?	Yes	( )	No	( )				
Do you drink?	Liquor	( )	Beer	( )	Wine	( )	Coffee ( )	No. of cups per day _____
Do you ever use recreational drugs?			Yes	( )	No	( )		
Do you routinely use seat belts?			Yes	( )	No	( )		
Do you have trouble sleeping?			Yes	( )	No	( )		
Is your sex life satisfactory			Yes	( )	No	( )		

   Does your life-style put you at risk for exposure to communicable or contagious diseases? Yes ( ) No ( )
9. CHIEF COMPLAINT: _____
   _____

REVIEW OF SYSTEMS (these questions are pertinent only to the interval since your last physical):

	YES	NO	PHYSICIAN'S COMMENTS
Unusual weight changes/unusual fatigue			
Skin rashes/change in moles			
Trouble with vision/eye symptoms			
Date of last eye exam:			
Difficulty hearing			
Nosebleeds			
Sinus trouble/hay fever			
Persistent hoarseness			
Constant or bothersome cough			
Difficulty breathing or other lung trouble			

REVIEW OF SYSTEMS (these questions are pertinent only to the interval since your last physical):

	YES	NO	PHYSICIAN'S COMMENTS
Chest pain, tightness, discomfort or pressure			
Swelling of feet or ankles			
Pain in calf when walking			
Fast or irregular heart beat (palpitations)			
High blood pressure			
Thyroid problems			
Had diagnosis of diabetes			
Do you do breast self-exams			
When was last mammogram			
Any breast lumps			
Abdominal pain			
Trouble swallowing			
Stomach trouble, indigestion, or heartburn			
Change in bowel habits			
Rectal bleeding or tarry/black stools			
Do you awake at night to urinate			
Trouble urinating or straining			
Prostate trouble			
Blood in urine/bladder or kidney infections			
Kidney stones			
Neck or back pain			
Swelling, stiffness or pain in any joint/muscle			
Any trouble walking			
Frequent or severe headaches			
Emotional problems			
Have you been depressed			
Any treatment for anemia			
Any blood transfusions			
Have you ever been rejected as a blood donor			

WOMEN ONLY: HAVE YOU HAD ... Hot flashes? Yes ( ) No ( )

What kind of birth control measures have you used?_____

Last Pap Smear (date): _____ Last Period (date): _____ Any change in periods? Yes ( ) No ( )

No. of miscarriages/pregnancies since last year? _____ Bleeding between periods? Yes ( ) No ( )

_____ _____

PATIENT SIGNATURE DATE