

**Women's Health Associates, PC**

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

<b>System Review</b>	<b>Please circle any of the following that are significant problems for you currently:</b>
General	NONE fever fatigue weight loss weight gain other:
Eyes, ENT (2)	NONE visual change headache sinusitis other:
Heart/Lungs	NONE swelling chest pain palpitation shortness of breath wheezing cough
Gastrointestinal	NONE constipation diarrhea indigestion nausea bloody stool pain fecal loss
Urinary / Vaginal	NONE frequency urgency pain blood loss of urine pain bleeding PMS abnormal discharge
Musculoskeletal	NONE weakness muscle pain joint pain other:
Skin / Breast	NONE rash ulcers pigmented lesions breast pain lump discharge other:
Neurological	NONE fainting seizures numbness tremor anxiety depression crying spells other:
Endocrine	NONE excessive thirst hot flashes hair loss heat or cold intolerance
Blood / Lymph	NONE bleeding bruises enlarged lymph nodes other:

MEDICAL HISTORY: (Any recently diagnosed illnesses)

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FAMILY HISTORY: (Any recently diagnosed disease of close family i.e. parents, siblings, and children)

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SOCIAL HISTORY: (Any changes in marital status, social habits i.e. smoking, alcohol or drugs)

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STEVEN A RABIN, MD

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KELLEY B. DOPSON, MD