DR. JIM'S SHOTS FOR HEALTH

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Female Medical and Health Survey

Accurate completion of this form will assure that you receive the best possible consultation

Name: Age: E-mail:

Address: City: St: Zip:

Home Phone: Cell Phone: Marital Status: Birthdate:

Occupation: Best Days and Times to Reach You:

How Did You Hear About Us-Please Be Specific:

Height: Weight: Blood Pressure: Heart Rate:

List Illnesses and Dates:

List Surgeries, Hospitalizations and Dates:

All Allergies:

Personal Physician Name and Address & Phone#:

Please describe you major problems and/or symptoms. If none, please write your reason for seeking this consultation. Please be clear and concise to help us help you. Include when the symptoms first appeared. Write what you can in the space provided. If you need more space, add a separate sheet of paper.

HEART DISEASE RISK FACTORS

YES	NO	
		Age Years - Male ≥ 45 or Female ≥ 55 or early menopause without estrogen replacement therapy
		Family history of premature Heart Disease (definite myocardial infarction or sudden death before 55 in father / close male relative, or 65 in mother / close female relative)
		Current cigarette smoker
		Hypertension (Blood pressure ≥ 140/90 mm Hg confirmed by measurements on several occasions or taking antihypertensive medication
		Low HDL (good) cholesterol (<35 mg/dl confirmed by measurements on several occasions [0.9 mmo/L]
		Diabetes mellitus (sugar)
		High HDL (good) cholesterol (≥ 60 mg/dl [1.6 mmo/L]

FAMILY HISTORY:	LIVING	AGE	Health Problems**, Mental Illnesses or Cause of Death
FATHER	Y N		
MOTHER	Y N		
BROTHERS/SISTERS	#		
CHILDREN	#		

** Cancer, Thyroid, Hypertension, Heart Disease, Stroke, Diabetes, Aortic Aneurysm, Asthma

REVIEW OF SYSTEMS:

Do you have now or have you ever had any problems with any of the following?

1	HEAD, NECK	Y N
2	EYES, VISION	Y N
3	EARS, HEARING	Y N
4	TEETH	Y N
5	NOSE, MOUTH, VOICE	Y N
6	LUNGS, BREAST, CHEST	Y N
7	HEART	Y N
8	ARTERIES, VEINS	Y N
9	STOMACH, GALLBLADDER	Y N
10	LIVER, PANCREAS	Y N
11	BOWELS, RECTUM, HERNIA	Y N
12	KIDNEY, BLADDER	Y N
13	UTERUS, VAGINA	Y N

14	BACK, SHOULDER BLADES	Y N
15	RIBS, HIPS	Y N
16	ARMS, LEGS	Y N
17	NERVE, BRAIN DISEASE	Y N
18	SEIZURE, MIGRAINES	Y N
19	SKIN PROBLEMS	Y N
20	BLOOD DISEASES, SPLEEN	Y N
21	GLANDS, OBESITY	Y N
22	CANCER	Y N
23	PREGNANT	Y N
24	PSYCHIATRIC PROBLEMS	Y N
25	OTHER CONDITIONS	Y N

EXPLAIN any YES answers:

SMOKE	Y N	HOW LONG:	PACKS PER DAY:
ALCOHOL	Y N	HOW LONG:	HOW MUCH:
STREET DRUGS	Y N	TYPE:	HOW OFTEN:
CAFFEINE BEVERAGES	Y N	TYPE:	QUANTITY:
SLEEP PROBLEMS	Y N	TYPE:	
EXERCISE REGULAR	Y N	TYPE:	HOW OFTEN:

Read carefully through the list of symptoms in each group, and put a check mark next to each symptom that you have. (If you check off the same symptom in more than one group, that's fine.)

Symptom Group 1

PMS_____ Insomnia_____ Early miscarriage_____
Painful and/or lumpy breasts_____ Unexplained weight gain_____ Anxiety_____
Cyclical headaches_____ Infertility_____
*TOTAL BOXES CHECKED*_____

Symptom Group 2

Vaginal dryness_____ Night sweats_____ Painful intercourse_____
Memory problems_____ Bladder infections_____ Hot flashes_____
Lethargic depression_____
*TOTAL BOXES CHECKED*_____

Symptom Group 3

Puffiness and bloating_____ Breast tenderness_____ Rapid weight gain_____
Heavy bleeding_____ Mood swings_____ Migraine headaches_____
Anxious depression_____ Foggy thinking_____ Insomnia_____
Weepiness_____ Gallbladder problems_____ Red flush on face_____
Cervical dysplasia (abnormal pap smear)_____
*TOTAL BOXES CHECKED*_____

Symptom Group 4

A combination of the symptoms in #1 and #3_____

Symptom Group 5

Acne_____ Infertility_____ Ovarian cysts_____
Excessive hair on face and arms_____ Thinning hair on the head_____ Mid-cycle pain_____
Polycystic ovary syndrome (PCOS)_____
Hypoglycemia and/or unstable blood sugar_____
*TOTAL BOXES CHECKED*_____

Symptom Group 6

Debilitating fatigue_____ Unstable blood sugar_____ Foggy thinking_____
Low blood pressure_____ Thin and/or dry skin_____ Brown spots on face_____
Intolerance to exercise_____
*TOTAL BOXES CHECKED*_____

Date of last pap smear _____ Was it normal?_____
If no, explain._____

Date of last Mammogram _____ Was it normal? _____
If no, explain._____
Date stools last checked for blood?_____ Normal?_____If no, explain_____
Date of last sigmoidoscopy or colonoscopy?_____Normal?_____ If no, explain _____

Please attach a list of all Prescription Medications and Over-the-Counter Medications you are taking .

Use this space for extra comments.