INTERVAL HISTORY

Name_____ Age _____ Date _____

1. **Have there been any changes** in your health since your last appointment such as illness, diseases, surgeries, hospitalizations? _____
   _____
2. **Please list the concerns you wish to discuss today.** _____
   _____
   _____
3. **Are you currently taking any prescription medications?**
   Name: _____ Dosage_____ Reason _____
   Name: _____ Dosage_____ Reason _____
   Name: _____ Dosage_____ Reason _____
   Name: _____ Dosage_____ Reason _____
4. **Are you currently taking any vitamins, non-prescription, or herbal medications?**
   Name: _____ Dosage_____ Reason _____
   Name: _____ Dosage_____ Reason _____
   Name: _____ Dosage_____ Reason _____
5. **Please list ALL ALLERGIES/ REACTIONS TO MEDICATIONS** _____
   _____
   _____
6. What was the first day of your last menstrual period? _____
7. Are your periods regular? _____ Are they changing? _____
8. What are you using for birth control? _____
9. Do you smoke cigarettes? _____ How many per day? _____
10. Do you exercise? _____ How often? _____
11. Do you consume caffeine? _____ How much? _____
12. Do you take calcium? _____ Other vitamins/supplements? _____
    _____
13. Do you drink alcohol? _____ How many drinks per day? _____
14. Do you have a sexual partner? _____
15. Do you have any sexual concerns? Yes _____ No _____
16. Do you do a self breast examination? _____
17. When was your last mammogram? _____
18. Have you ever had colonoscopy? _____ When? _____
19. When did you last have blood tests? _____
20. Has a close blood relative died or developed a major illness since your last visit? _____
    _____
21. Are you having problems with stress, PMS, depression, anxiety, martial problems, domestic violence, eating disorders, substance abuse? _____
    _____
    _____
22. Are you having any problems controlling leakage of urine or stool? _____
    _____