Mobile Reproductive Endocrinology & Infertility

6332 Piccadilly Square Dr. Mobile, AL 36609

Patient Name:_____

Date:_____ Chart #:_____

Health History and Review of Systems

Please list **all** illnesses and surgeries that you have below:

SURGERY/REASON/ILLNESS	DATE	PHYSICIAN	HOSPITAL

Family History

Please list any illnesses that run in your family:

ILLNESS	WHO & AGE OF ONSET	PHYSICIAN'S NOTES

Current Medications & Vitamins

Please list **ALL** substances you use: medications, vitamins, creams, gels, patches or injectable

NAME OF DRUG/VITAMIN	DOSAGE & DIRECTIONS	PHYSICIAN

Mobile Reproductive Endocrinology & Infertility

6332 Piccadilly Square Dr. Mobile, AL 36609

Patient Name:_____

Date:_____ Chart #:_____

WHAT SYMPTOM **ARE YOU HAVING TODAY?**	**Y or N**	***WHAT SYMPTOM*** **ARE YOU HAVING TODAY?**	**Y or N**
BREASTS		**GENITOURINARY**	
Pain		Blood or Pain with urination	
Lump		Urgency or Frequency	
Nipple discharge		Incomplete urination	
CARDIOVASCULAR		Involuntary urine loss	
Chest Pain or Pressure		Abnormal vaginal bleeding/Irregular Periods	
Breathing difficulty		Painful periods	
Swelling of legs		PMS	
Rapid or Irregular heartbeat		Pain during sex	
CONSTITUTIONAL		Abnormal vaginal discharge	
Weight loss or gain		Vaginal dryness or irritation	
Fever		**HEMATOLOGIC/LYMPHATIC**	
Fatigue		Frequent bruises	
Change in height		Cuts do not stop bleeding	
EARS, EYES, NOSE, THROAT		Enlarged Lymph nodes	
Vision Changes		**MUSCULOSKELETAL**	
Glasses/Contacts		Weakness	
Hearing Problems		Joint pain	
Ringing or Pain		**NEUROLOGIC**	
Sinus Problems		Dizziness or Numbness	
Sore Throat or Mouth		Seizures or Headaches	
Dental Problems		Trouble walking	
ENDOCRINE		Memory problems	
Hair loss		**PSYCHIATRIC**	
Heat/Cold intolerance		Depression	
Abnormal thirst		Anxiety	
Hot flashes/Night sweats		Mood Swings	
Insomnia		**RESPIRATORY**	
GASTROINTESTINAL		Painful breathing/Shortness of breath	
Diarrhea or Constipation		Wheezing or Cough	
Bloody Stool		Spitting up blood	
Nausea/Vomiting		**SKIN**	
Involuntary loss of gas or stool		Rash, Moles or Sores	
Abdominal Pain/Pelvic Pain		Dry skin	
ALLERGIES *Please list the name of **drug** or **substance** you are allergic to & its reaction.*			

Form completed by: _____ Patient_____ Nurse _____ Physician _____ Other

Patient Signature: _____ Print Name _____

Physician Signature: _____ Date _____