FAMILY DOCTORS OF VICKSBURG PC
13320 NORTH BOULEVARD ST. VICKSBURG MI 49097 269-649-2012 FAX: 269-649-3752

HISTORY FORM- FEMALE OVER 65

Name: _____ DOB: _____ Date: _____

Please describe any concerns you have: _____

Family History: Do you have a grandparent, parent, sibling or child with the following:

CANCER	YES	NO	If YES, who?	----------	YES	NO	If YES, who?
Uterine				Stroke			
Ovarian				Glaucoma			
Breast				Osteoporosis			
Colon				Hip Fracture			
Skin				Alcoholism			
Heart Attack				Depression			
Heart Bypass				Aneurysm			

Social History (circle please)

1. **Who lives with you?**
   No one /Spouse /Relative /Paid Helper / Friend
2. **Has there been any of these changes in your family?**
   Birth / Marriage / Death / Job Change
3. **Do you have a pet? Yes / No what kind? _____**
4. **What kind of work do/did you do? _____**
5. **Have you ever used tobacco? Yes / No**
   If YES: Average packs per day _____
   Number of years you smoked _____
   The year you quit _____
   When are you planning to quit?
   Now / 6 months / Sometime / Never
6. **Do you drink alcohol? Yes / No**

If YES	Y	N
Have you ever felt you should cut down?		
Have people ever annoyed you by nagging about your drinking?		
Have you ever felt guilt about your drinking?		
Have you ever had a drink first thing in the morning?		
Has drinking ever affected your job performance?		
Have you ever drank and driven a vehicle?		

Do you exercise? Yes / No
Activity _____ Number of days per week ____
Time/duration _____ minutes/hours _____
Exertion: Stroll / Mild / Heavy

Do you always wear seat belts? Yes / No

Does your house have a working smoke detector? Yes / No

Do you have firearms at home? Yes / No

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Gynecological History

Have you ever had an abnormal pap smear? Yes / No
If yes, have you ever had any of the following?
Colposcopy / Biopsy / Surgery
Number of times you have been pregnant _____
Number of completed pregnancies _____
Age at which your periods stopped _____
Have you had any vaginal bleeding since your period stopped? Yes ___ No ___
Have you noticed any breast lumps? Yes ___ No ___
Do you experience pain with intercourse? Yes ___ No ___
Are you afraid to return to your current living situation? Yes ___ No ___
Do you take any of the following?
Calcium Yes ___ No ___
Vitamin D Yes ___ No ___
Estrogen or hormone replacement Yes ___ No ___

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7.Prevention
Which of the following are included in your diet?

	Grains	Veggies	Dairy	Meats	Sweets
A lot					
Some					
Few					

FEMALE OVER 65 REVIEW OF SYSTEMS

1. **Which of the following can you do without help? Please check all that you can do on your own.**

	Get out of bed		Dress/undress		Pay bills
	Prepare meals		Use telephone		Housework
	Bathe/shower		Use toilet		Do laundry
	Take medicine correctly		Walk		Shop

Have you fallen in the past year?
Yes / No

2. **Do you have difficulty with any of the following? Check all the ones you have difficulty with.**

	Balance/steadiness		Bowel control		Depression
	Vision		Memory		Appetite
	Hearing		Sleep		Walking
	Bladder control		Constipation		Balance

3. **Do you have?**

Yes	No	Unsure	CONST	Yes	No	Unsure	GI
			Weight change				Use antacids frequently
			Loss of appetite				Does food get stuck when you swallow
			Problem sleeping				Black or bloody stools
			DERM				Constipation
			Changing mole				Abdominal pain
			Sore that won't heal				Recurrent diarrhea
			Rash				ENDO
			EYES				Do you feel hotter or colder than others?
			Double vision				MUSCULOSKELETAL
			Eye pain				Pain in legs when walking
			ENT				Joint pain
			Hearing loss				ALLERGY
			Balance problems				High fever
			Recurrent sinus/nasal congestion				Severe reaction to bee stings
			Swelling in the neck				Severe reaction to food
			CARDIOVASCULAR	What time of the year do these appear?			
			Wake up at night short of breath				NEUROLOGY
			Legs swell at end of day				New headache
			Chest discomfort when you walk				Frequent headache
			Heart pounds or skips a beat				Stroke that came and went away
			Have you fainted/passed out				PSYCH
			RESPIRATORY				Panicky feeling
			Chronic cough				Trouble remembering things

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			Cough up blood				**Feel depressed**
			Shortness of breath at rest				**Wake up frequently**
GU				**Over the past two weeks have you felt down depressed or hopeless? Yes ___ No ___** **Over the past two weeks have you felt little interest or pleasure in doing things? Yes ___ No ___**			
			Burning with urination				
			Loss of bladder control				
			Blood in urine				
How many times do you urinate at night?							

Please list all medical suppliers (oxygen, diabetic supplies) or home health agencies

1. _____

_____

_____

Please list all other Doctors/ Specialists:

2. _____

_____

_____

_____