Willow Medical Spa
Health History/Review of Systems

Patient Name: _____ Date: _____

DOB: _____ Age: _____ Occupation: _____

PCP: _____ Other Providers I see: _____

General Health (circle): Excellent Good Fair Poor

Reason for Seeking Medical Attention: _____

Review of Systems: **check** any of the following symptoms you have experienced in the **past year.**

Constitutional	Cardiovascular	Reproductive	Neurological	Musculoskeletal
○ Chills ○ Fever ○ Weight Gain ○ Weight Loss	○ Chest Pain ○ Poor Circulation ○ Swelling legs ○ Palpitations ○ Irregular heart rhythm ○ Other _____	○ Painful Periods ○ Painful Sex ○ Vaginal discharge ○ Breast discharge ○ Breast lump	○ Dizziness ○ Leg/arm numbness ○ Leg/arm weakness ○ Problems with walking ○ Headache ○ Memory loss ○ Seizures ○ Tremors ○ Other	○ Back pain ○ Joint pain ○ Joint swelling ○ Muscle weakness ○ Neck pain ○ Other _____
HEENT	**Gastrointestinal**	**Integumentary** (skin, hair, nails)	**Psychiatric**	**Hematologic/ Lymphatic**
○ Hearing loss ○ Pain in the head ○ Nasal drainage ○ Visual changes ○ Allergy symptoms ○ Head cold	○ Stomach pain ○ Blood in stool ○ Change in stool ○ Constipation ○ Diarrhea ○ Heartburn ○ Change of appetite ○ Nausea ○ Vomiting ○ Other _____	○ Hair loss ○ Abnormal hair growth ○ Hives ○ Itchiness ○ Rash ○ Skin lesion ○ Other _____	○ Anxiety ○ Depression ○ Trouble sleeping ○ Other _____	○ Easy bleeding ○ Easy bruising ○ Swollen lymph nodes ○ Other _____
Respiratory	**Genitourinary**	**Metabolic/ Endocrine**	**Immunologic**	**Other**
○ Cough ○ Shortness of breath ○ Wheezing ○ Other _____	○ Burning with urination ○ Blood in urine ○ Lots of urine ○ Frequent urination ○ Urinary incontinence ○ Urinary retention	○ Cold intolerance ○ Heat intolerance ○ Always thirsty ○ Always hungry ○ Other _____	○ Contact allergy ○ Environmental allergy ○ Food allergy ○ Seasonal allergy ○ Frequently getting sick ○ Other _____	○ Traveled outside USA? ○ Seen a Specialist MD? ○ Had any hospitalizations, surgery or been to Urgent Care?

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Personal History (please circle and date those **YOU** have had)

	Date:		Date:
AIDS/HIV Positive:		Hernia	
Anemia		High Blood Pressure	
Angina/Heart Pain		Kidney Disease or Stones	
Arthritis or Rheumatism		Liver Disease	
Asthma or Hay Fever		Lung Disease	
Bladder or Prostate Trouble		Mental Illness	
Blood Transfusion		Migraine Headache	
Bone Disease		Paralysis	
Cancer:		Pneumonia	
Cholesterol/Triglyceride Problem		Polio	
Chronic Bronchitis		Polyps, Colon	
Colitis or Bowel Disease		Phlebitis (Clot)	
Diabetes		Scarlett Fever	
Eating Disorder		Seizures/Convulsions	
Emotional Disorder		Skin Trouble/Disease	
Eye Disease or Glaucoma		Stroke	
Gall Bladder Disease		Thyroid Disease	
Gout		Tonsils Removed (Age)	
Heart Disease		Tuberculosis	
Head Injury		Ulcers	
Hepatitis:		Urinary Tract Infection	
Other:			

Please indicate if you had vaccine or virus and when

Measles: _____ Mumps: _____ Rubella: _____

Chicken Pox: _____ Rheumatic Fever: _____

Preventative Care/Immunizations History (please date those you have had with the most current)

Diphtheria/Pertussis Tetanus: _____ Flu: _____ Pneumonia: _____

Gardasil Vaccine (HPV): _____ Shingles: _____ Meningitis: _____

Colonoscopy: _____ Pap: _____ Bone Density: _____ Mammogram: _____

Female Health History

Age of 1st period: _____ 1st day of last period: _____ Age periods stopped: _____

Currently pregnant: Y / N # of pregnancies: _____ # of live births: _____

Method of Birth Control: _____ Have you ever had an STD? Y/N Type_____

Have you ever had an abnormal pap: Y / N Date: _____ # of sex partners in past year? ____

Do you have history of: Endometriosis Ovarian Growths Fibroids DES exposure Infertility

Decrease or increase in sexual desire? Y / N Sexual Orientation: G L B T Q Hetero

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Medicines: (include Non-Prescription Drugs, Herbs and Vitamins)

Current Medication	Size/Dose	How you take

Allergies (medicine/food/etc.)	**What was your reaction?**

Social: Have you participated in the following?

Alcohol	No	Yes	How Often/Much:	
Tobacco	No	Yes	How many per day:	Quit Date:
Illicit Drugs	No	Yes	How Often:	Quit Date:
Caffeine	No	Yes	How Often/Much:	
Energy Drinks	No	Yes	How Often:	
Regular Exercise	No	Yes	Minutes:	How many times per week:
Weight:	Current:		1 year ago:	5 years ago:

Are there any cultural or personal beliefs that you would like me to know about?

_____

Are you currently or have you ever been in a relationship where you were hurt, threatened or made to feel afraid? Yes / No

Who do you live with? _____ House / Apartment / Other: _____

List any previous Hospitalizations, Chronic Illness, Surgeries, Injuries or Accidents

(List cause or type, include Psychiatric but omit pregnancies)	**Year**

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Family History	Age	Health	Age @ Death	Cause	Has any blood relative ever had: (if yes, indicate relation and age of onset)	
Father					Allergy/Asthma	
Mother					Arthritis/Gout	
Siblings: (m/f)					Bleeding Disorder	
1					Clotting Disorder	
2					Cancer	
3					Colon Polyp	
4					Depression	
5					Diabetes	
					Epilepsy/Seizures	
Spouse					Glaucoma	
Children: (m/f)					Heart Disease	
1					Coronary Artery Disease	
2					High Blood Pressure	
3					Liver Disease	
4					Kidney Disease	
5					Mental Illness	
					Alcohol/Substance Abuse	
					Migraines	
					Overweight	
					High Cholesterol	
					Stroke	
					Thyroid Disease	
					Osteoporosis	
					Endometriosis	
					Hysterectomy	
					Ovarian Cysts	

Prevention/Wellness

Would you like help with:

Weight Loss? Yes / No

Stopping Tobacco Use? Yes / No

An Exercise Program? Yes / No

Immunizations? Yes / No

Food and/or housing? Yes / No

Other: _____

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