Willow Health and Aesthetics
Health History/Review of Systems

Patient Name: ______________________________ Date: ______________

DOB: ______________ Age: ______________ Occupation: ______________

PCP: ______________________________ Other Providers I See: ______________

General Health (circle): Excellent Good Fair Poor Preferred Pharmacy: ______________

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?

________Reviewed with patient on ______________.

Willow Health and Aesthetics
Health History/Review of Systems

Patient Name: ____ Date: ____________________

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: ___________ Labs: ____________
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

________Reviewed with patient on _______________.

Willow Health and Aesthetics
Health History/Review of Systems

Patient Name: ____ Date: ________________

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

Current Medication	Size/Dose	How often 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**

________Reviewed with patient on ______________.

Willow Health and Aesthetics
Health History/Review of Systems

Patient Name:____ Date:___________________

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: ____

________Reviewed with patient on ______________.