Please **circle/answer** **just** the **UNDERLINED** **QUESTIONS!** **NAME:** ______________________________ ______________________________________ ________ 1

CONFIDENTIAL *Thank you!* *W Slaughter MD 49 Hancock Cambridge MA 02134 cc/hpi info,ros(p+14),pmh/AxIII*

WHAT IS/ARE THE MAIN ISSUE/S YOU'D LIKE TO MEET ABOUT?

When did this start? *(dur)*

Timing: How has/have do/does this/these vary over time—episodes, frequency, variations?

What makes coping easier/more challenging t? *(md f's: actv intprs meds genmed ptx)*

What are any associated signs and symptoms?

Circle No or Yes:	Pls **circle/note specifics** for any current/past problems, conditions, medications, surgeries, hospitalizations, concerns, questions, issues, challenges, etc for these other body systems/areas below—including any family hereditary sorts of conditions. We'll consider how these may/may not/clearly do tie in to mental/emotional/psychological health…	**Pls do not write in this column below** CondsMeds/Srg/AIII
No or Yes:	GYNECOLOCIC/OBSTETRIC/FEMALE REPRODUCTIVE (menstrual challenges, abnormal PAP smear findings, pregnancy early terminations, others):	
No or Yes:	ALLERGIC/IMMUNOLOGIC (*DRUG ALLERGIES* /Reports nkda , hay fever/seasonal allergies, others):	
No or Yes:	ENDOCRINE/HORMONAL (thyroid, excessive thirst/hot or cold feelings, diabetes, tiredness/sluggishness, others):	
No or Yes:	OVERALL/"CONSTITUTIONAL" (fever, chills, headache, tiredness/ sluggishness, others):	
No or Yes:	EYES (vision blurred, dryness, glaucoma, cataracts, prescription or reading glasses, others):	
No or Yes:	DIGESTIVE/GASTROINTESTINAL (hepatitis/other liver problems, diarrhea, constipation, pains, nausea, vomiting, indigestion, heartburn, others):	
No or Yes:	URINARY/GENITAL (genital area pain, sexual problems, kidney/bladder/urination problems, sexually transmt'd diseases, others):	
No or Yes:	HEART/BLOOD VESSELS/CARDIOVASCULAR (heart, blood vessels, varicose veins, chest pain, high blood pressure, arrhythmias/irregular heart beats, others):	
No or Yes:	BLOOD/HEMATOLOGIC/LYMPHATIC (blood clotting issues, component/vitamin abnormalities/anemia, cholesterol, swollen glands, others):	
No or Yes:	ARMS/LEGS/ BONES/MUSCLES/SKELETAL (pain, joints, muscles, bones, back, neck, others):	
No or Yes:	NEUROLOGICAL (tremors, dizziness, numbness/tingling, migraine/head ache, seizure, stroke, others):	
No or Yes:	RESPIRATORY (lungs, breathing problems, asthma, shortness of breath, others):	
No or Yes:	SKIN/BREAST (pain, rashes, itching, mammography abnormalities, others):	
No or Yes:	EARS/NOSE/TEETH/MOUTH/THROAT (ear pain/infection, sore throat, sinus problems, dental status, tinnitus, others):	

E:C **HEIGHT:** ____________ **WEIGHT:** ______ *RR* *GAp* **apr cas cl wlgr** biz dsh dfor

CURRENT MENTAL HEALTH MEDICATIONS/ none:

MENTAL HEALTH PROVIDERS--COUNSELORS, PRESCRIBERS ETC by discipline/ none:

CURRENT PRIMARY CARE DOC/CLINIC or None:

Other healthcare providers (GYN, etc)/ none:

Alcohol, tobacco, other 'substances'/ none:

PRIOR MENTAL HEALTH MEDICATIONS/ none:

Mental Health diagnoses/ none:

Treatment: "Outpatient" (office, clinic-based, etc)/ none:

Inpatient (hospitalized) No, or Yes (when, where, reason):