

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 intrps 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/All
No or Yes:	<u>GYNECOLOGIC/OBSTETRIC/FEMALE REPRODUCTIVE</u> (menstrual challenges, abnormal PAP smear findings, pregnancy early terminations, others):	
No or Yes:	<u>ALLERGIC/IMMUNOLOGIC</u> (<i>DRUG ALLERGIES</i> /Reports nkda, hay fever/seasonal allergies, others):	
No or Yes:	<u>ENDOCRINE/HORMONAL</u> (thyroid, excessive thirst/hot or cold feelings, diabetes, tiredness/sluggishness, others):	
No or Yes:	<u>OVERALL/"CONSTITUTIONAL"</u> (fever, chills, headache, tiredness/ sluggishness, others):	
No or Yes:	<u>EYES</u> (vision blurred, dryness, glaucoma, cataracts, prescription or reading glasses, others):	
No or Yes:	<u>DIGESTIVE/GASTROINTESTINAL</u> (hepatitis/other liver problems, diarrhea, constipation, pains, nausea, vomiting, indigestion, heartburn, others):	
No or Yes:	<u>URINARY/GENITAL</u> (genital area pain, sexual problems, kidney/bladder/urination problems, sexually transmt'd diseases, others):	
No or Yes:	<u>HEART/BLOOD VESSELS/CARDIOVASCULAR</u> (heart, blood vessels, varicose veins, chest pain, high blood pressure, arrhythmias/irregular heart beats, others):	
No or Yes:	<u>BLOOD/HEMATOLOGIC/LYMPHATIC</u> (blood clotting issues, component/vitamin abnormalities/anemia, cholesterol, swollen glands, others):	
No or Yes:	<u>ARMS/LEGS/ BONES/MUSCLES/SKELETAL</u> (pain, joints, muscles, bones, back, neck, others):	
No or Yes:	<u>NEUROLOGICAL</u> (tremors, dizziness, numbness/tingling, migraine/head ache, seizure, stroke, others):	
No or Yes:	<u>RESPIRATORY</u> (lungs, breathing problems, asthma, shortness of breath, others):	
No or Yes:	<u>SKIN/BREAST</u> (pain, rashes, itching, mammography abnormalities, others):	
No or Yes:	<u>EARS/NOSE/TEETH/MOUTH/THROAT</u> (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:

PRIOR MENTAL HEALTH MEDICATIONS/ none:

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

Mental Health diagnoses/ none:

CURRENT PRIMARY CARE DOC/CLINIC or None:

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

Other healthcare providers (GYN, etc)/ none:

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

Alcohol, tobacco, other 'substances'/ none: