NORTHSIDE HOSPITAL

North Point Primary Care

LONG H. LE. M.D., P.C.

NAME_____ **DOB** _____ **Date** _____

Please answer the following questions:

Do you have any skin problems?	**YES**	**NO**
Have you had any recent fever, chills, or night sweats?	**YES**	**NO**
Have you had any recent weight gain or loss?	**YES**	**NO**
Do you often feel hot when others around you are comfortable?	**YES**	**NO**
Do you often feel cold when others around you are comfortable?	**YES**	**NO**
Do you have an excessive thirst for liquids?	**YES**	**NO**
Do you have any hearing problems?	**YES**	**NO**
Do you wear glasses or contact lenses?	**YES**	**NO**
Do you have any eye problems other than glasses?	**YES**	**NO**
Are you under a great deal of stress?	**YES**	**NO**
Do you feel depressed or cry frequently?	**YES**	**NO**
Do you have sinus problems?	**YES**	**NO**
Do you have frequent or severe headaches?	**YES**	**NO**
Do you get shortness of breath easily or frequently?	**YES**	**NO**
Do you have frequent coughing?	**YES**	**NO**
Does your heart beat rapidly or skip beats?	**YES**	**NO**
Do you ever have chest pain or chest tightness?	**YES**	**NO**
Do your legs or ankles swell?	**YES**	**NO**
Do you have frequent or severe pain in your stomach or abdomen?	**YES**	**NO**
Do you have frequent diarrhea?	**YES**	**NO**
Have you had nausea, vomiting, or vomiting blood?	**YES**	**NO**
Do you have a problem with constipation?	**YES**	**NO**
Have you seen blood in your bowel movements?	**YES**	**NO**
Are your bowel movements ever black?	**YES**	**NO**
Have you seen blood in your urine?	**YES**	**NO**
Do you have burning or discomfort when you urinate?	**YES**	**NO**
Do you have pains in your joints?	**YES**	**NO**
Are you having problems with your sex life?	**YES**	**NO**
How many times do you awake at night to urinate?		_____

FOR WOMEN ONLY:

Do you have vaginal itching, burning, or discharge?	**YES**	**NO**
Have you ever had an abnormal PAP smear?	**YES**	**NO**
If you are still having menstrual periods: Are your periods irregular?	**YES**	**NO**
Are menstrual cramps a problem for you?	**YES**	**NO**

What method of contraception are you currently using? (Please circle)

None **Pills** **IUD** **Condoms** **Vasectomy** **Tubal ligation** **Rhythm** **Foam/Sponge** **Other**

If you have stopped having periods: Do you have hot flashes?	**YES**	**NO**
Have you had any vaginal bleeding?	**YES**	**NO**
How old were you when you started to have menstrual cycles?		_____
How many times have you been pregnant?		_____
At what age did you have your first baby?		_____
How many miscarriages or abortions have you had?		_____
When was your last menstrual period?		_____
If you have gone through menopause, how old were you when that occurred?		_____

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REVIEW OF SYSTEMS