Confluence HEALTH

PLACE LABEL HERE, IF AVAILABLE
IF NOT, FILL IN FOLLOWING INFORMATION:

PATIENT NAME:_____

HISTORY NUMBER: _____

PATIENT DATE OF BIRTH: _____

LOCATION OF SERVICE: _____

DATE OF SERVICE: _____

HEALTH SURVEY - FEMALE

Please check if you have experienced any of the following since your last visit.

GENERAL
- ☐Weight gain
- ☐Weight loss
- ☐Fatigue
- ☐Sweats
- ☐Night sweats
- ☐Fever
- ☐Chills

SKIN
- ☐Rashes
- ☐Itching
- ☐Sores
- ☐Hives
- ☐Changing moles
- ☐Hair loss

EYES
- ☐Glasses
- ☐Blurring
- ☐Double vision
- ☐Spots
- ☐Redness
- ☐Pain
- ☐Change in vision

EARS
- ☐Pain
- ☐Decreased hearing
- ☐Ringing noises
- ☐Discharge

NOSE & SINUSES
- ☐Infections
- ☐Bleeding
- ☐Post-nasal drip
- ☐Hay fever/allergy
- ☐Trouble smelling

MOUTH
- ☐Dentures
- ☐Gum problems
- ☐Toothache
- ☐Sore throats
- ☐Hoarseness

RESPIRATORY
- ☐Wheezing
- ☐Shortness of breath
- ☐Cough
- ☐Cough up blood

CARDIOVASCULAR
- ☐Chest pain
- ☐Palpitations
- ☐Irregular heartbeat
- ☐Heart murmur
- ☐Ankle swelling
- ☐High blood pressure
- ☐Trouble breathing when lying flat
- ☐Wake up short of breath at night
- ☐Pain in the calves when walking

FEMALE
First day of last menstrual period:_____
- ☐Still having periods
- ☐Sexually active
- ☐Irregular period
- ☐Heavy periods
- ☐Cramps / pain
- ☐Missed periods
- ☐Menopause symptoms
- ☐Sexual function problems
- ☐Vaginal discharge
- ☐Spotting between periods
- ☐Breast lump
- ☐Breast pain
- ☐Miscarriage
- ☐Nipple discharge
- ☐History of abnormal pap smear
- ☐Pain with sex
- ☐Current contraception: _____

STOMACH & INTESTINES
- ☐Change in appetite
- ☐Indigestion
- ☐Heartburn
- ☐Pain
- ☐Diarrhea
- ☐Jaundice
- ☐Constipation
- ☐Hemorrhoids
- ☐Hernia
- ☐Vomiting blood
- ☐Blood in stool
- ☐Difficulty swallowing
- ☐Nausea / vomiting
- ☐Black tar-like stool
- ☐Change in bowel habits

URINARY
- ☐Frequent urination
- ☐Painful urination
- ☐Kidney stones
- ☐Night urination
- ☐Urgency
- ☐Hard to start stream
- ☐Blood in urine
- ☐Slow or weak stream
- ☐Leakage of urine

BLOOD
- ☐Easy bruising
- ☐Bleeding tendency
- ☐Anemia
- ☐ Blood transfusion (year_____)

PLEASE TURN PAGE OVER →

NERVOUS SYSTEM & PSYCHOLOGICAL

☐Headaches ☐Migraines
☐Anxiety ☐Fainting spells
☐Suicidal thoughts ☐Memory trouble
☐Seizures ☐Depression
☐Dizziness ☐Sleep disturbance or insomnia
☐Numbness in any part of the body
☐Weakness in any part of the body

Over the past 2 weeks, how often have you felt down, depressed or hopeless?
☐ Not at all ☐ Several days
☐ More than half the days ☐ Nearly every day

Over the past 2 weeks, how often have you felt little interest or pleasure in doing things?
☐ Not at all ☐ Several days
☐ More than half the days ☐ Nearly every day

☐Don't feel safe at home or in your current relationship

GLANDULAR

☐Goiter
☐Thyroid problems
☐Heat intolerance
☐Cold intolerance
☐High Blood Sugar
☐Low Blood sugar

MUSCLES & JOINTS

☐Painful joints
☐Joint swelling
☐Stiffness
☐Back pain
☐Gout
☐Weakness

HABITS / OTHER

Do you use alcohol? ☐ Yes ☐ No
Type:_____ # of drinks per week: _____

Are you currently a smoker? ☐ Yes ☐ No
# of packs per day?_____ How many years?_____

Are you a past smoker? ☐ Yes ☐ No
# of packs per day?_____ How many years?_____

Do you use chewing tobacco? ☐ Yes ☐ No # of cans per week? _____

Do you drink coffee? ☐ Yes ☐ No # of cups per day? _____

Have you ever used recreational drugs?
☐ Yes ☐ No Types:_____

Do you exercise regularly? ☐ Yes ☐ No Do you use seatbelts routinely? ☐ Yes ☐ No
Number of falls this year: _____ Do you worry about falling? ☐ Yes ☐ No

Do you have an advanced healthcare directive or living will? ☐ Yes ☐ No