the BOWEN CENTER for women's health

FAMILY HISTORY NAME:_____

Check illnesses which have occurred in any of your blood relatives

O Diabetes O Cancer O Bleeding Tendency O Kidney Disease O Tuberculosis
O Heart Disease O Stroke O High Blood Pressure O Nervous Illness O Allergy

Other_____

MEDICAL HISTORY (ALL INFORMATION IS CONFIDENTIAL)

Date of your last exam_____

What was the reason for your visit?_____

Check symptoms you currently have or have had in the past year.

O Chills	O Depression/Nervousness	O Dizziness/Fainting	O Fever
O Headache	O Loss of Sleep	O Loss of Weight	O Numbness
O Sweats	O Forgetfulness	O Poor Appetite	O Bloating
O Bowel Changes	O Constipation	O Diarrhea	O Excessive Thirst
O Gas	O Hemorrhoids	O Indigestion	O Nausea
O Rectal Bleeding	O Stomach Pain	O Vomiting	O Vomiting Blood
O Bleeding Gums	O Blurred Vision	O Crossed Eyes	O Difficulty Swallowing
O Double Vision	O Earache/Ear Discharge	O Hay Fever	O Hoarseness
O Loss of Hearing	O Nosebleeds	O Persistent Coughs	O Ringing in Ears
O Sinus Problems	O Vision- Flashes/Halos	O Hives	O Itching/Rash
O Change in Moles	O Scars	O Sore that won't heal	O Bruise easily
O Chest Pain	O High/Low Blood Pressure	O Irregular Heart Beat	O Poor Circulation
O Varicose Veins	O Swelling of Ankles	O Blood in Urine	O Lack of Bladder Control
O Painful Urination	O Frequent Urination		

Do you have or have you had pain, weakness, numbness in:
O Arms O Back O Feet O Hands O Hips O Legs O Neck O Shoulders

Do you have or have you had:
O Abnormal Pap Smear O Bleeding between periods O Breast Lump
O Hot Flashes O Nipple Discharge O Painful Intercourse
O Vaginal Discharge O Extreme Menstrual Pain

Other_____

Date of last menstrual period_____Date of last pap smear_____

Have you had a mammogram? O Yes O No Are you pregnant? O Yes O No # of Children_____

Please describe serious illnesses or surgeries_____

_____

_____

MEDICAL HISTORY CONTINUED

NAME:_____

Check conditions you have or have had in the past.

O AIDS	O Migraine Headaches	O Appendicitis
O Arthritis	O Asthma	O Bleeding Disorders
O Breast Lump	O Cancer	O Cataracts
O Chemical Dependency	O Chicken Pox	O Diabetes
O Emphysema	O Epilepsy	O Glaucoma
O Heart Disease	O Hepatitis	O Herpes
O High Cholesterol	O HIV Positive	O Kidney Disease
O Liver Disease	O Measles	O Multiple Sclerosis
O Mumps	O Pacemaker	O Pneumonia
O Polio	O Rheumatic Fever	O Scarlet Fever
O Stroke	O Thyroid	O Tuberculosis
O Ulcers	O Venereal Disease	

MEDICATIONS/ALLERGIES

List medications you are currently taking_____

_____

Pharmacy Name_____Phone #_____

List allergies to medications or substances_____

_____

HEALTH HABITS

Caffeine O Yes O No How much?_____ How often?_____

Tobacco O Yes O No How much?_____ How often?_____

Marijuana O Yes O No How much?_____How often?_____

Street Drugs O Yes O No How much?_____How often?_____

Alcohol O Yes O No How much?_____How often?_____

SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my caregiver if I, or my minor child, ever have a change in health.

_____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____

Please Print Above Name State Relationship to Patient