

# Interval History



**Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Do you have any of the following problems now, or have you had them since we last saw you?**

**General**

- Fever  no  yes
- Night sweats  no  yes
- Chills  no  yes
- Hot flashes  no  yes
- Aches or pains  no  yes
- General weakness  no  yes
- Memory loss  no  yes
- Swollen glands  no  yes
- Easy bruising  no  yes
- Unplanned weight change  no  yes
- Do you snore  no  yes
- Have you ever been told that you stop breathing during sleep  no  yes

**Head and Neck**

- Blurred vision  no  yes
- Double vision  no  yes
- Light flashes  no  yes
- Halos around lights  no  yes
- Ear pain  no  yes
- Drainage from ear  no  yes
- Hearing difficulty  no  yes
- Ringing in ears  no  yes
- Nosebleeds  no  yes
- Sinus trouble  no  yes
- Difficulty swallowing  no  yes
- Persistent hoarseness  no  yes
- Severe headaches  no  yes
- Neck swelling  no  yes
- Neck lumps  no  yes
- Other  no  yes

**Skin**

- Changing mole  no  yes
- Rash  no  yes
- Yellow skin  no  yes
- Do you do skin self exam  no  yes
- Other skin problem  no  yes

**Chest/Heart/Lungs**

- Shortness of breath  no  yes
- Poor exercise tolerance  no  yes
- Unusual heartbeat  no  yes
- Chest pain or pressure  no  yes
- Frequent cough  no  yes
- Coughing up blood  no  yes
- Wheezing  no  yes
- Swollen ankles  no  yes
- Leg Cramps  no  yes
- Other  no  yes

Do you have any special worries or concerns about your health  no  yes

List any medications/vitamins/herbs: \_\_\_\_\_

**Gastrointestinal**

- Poor appetite  no  yes
- Indigestion or heartburn  no  yes
- Nausea or vomiting  no  yes
- Abdominal pain or cramps  no  yes
- Abdominal swelling  no  yes
- Diarrhea  no  yes
- Constipation  no  yes
- Change in bowel habits  no  yes
- Bleeding from rectum  no  yes
- Black, tar-like stool  no  yes
- Other  no  yes

**Kidney**

- Blood in urine  no  yes
- Pain or burning while urinating  no  yes
- Difficulty with urination  no  yes
- Up at night to urinate  no  yes
- Urine leaking  no  yes
- Other  no  yes

**General Reproductive**

- How many people have you had sexual contact with in the past year?  0  1  2-3  4+
- Birth control used  no  yes
- What type? \_\_\_\_\_
- Sexually active now?  no  yes
- in the past year?  no  yes

**Women Reproductive**

- Last menstrual period: \_\_\_\_\_
- Breast lump  no  yes
- Discharge from nipple  no  yes
- Do you do self breast self exam  no  yes
- Vaginal Discharge  no  yes
- Vaginal bleeding or spotting not with periods  no  yes
- Pain with periods  no  yes
- Pain with intercourse  no  yes
- Possibly pregnant  no  yes
- Change in periods  no  yes
- Pain not with periods  no  yes
- Other  no  yes

**Men Reproductive**

- Breast lump  no  yes
- Discharge from penis  no  yes
- Sore on penis  no  yes
- Lump in testicles  no  yes
- Difficulty with erections  no  yes
- Do you do testicular self exam?  no  yes
- Other  no  yes

**Neuromuscular**

- Weakness in arm or leg  no  yes
- Difficulty with balance  no  yes
- Dizzy spells  no  yes
- Fainting spells  no  yes
- Speech difficulty  no  yes
- Numbness or tingling  no  yes
- Other  no  yes

**Bones/Joints**

- Painful joints  no  yes
- Swollen joints  no  yes
- Loss of muscle strength  no  yes
- Lump in muscle or bone  no  yes
- Back pain  no  yes
- Other  no  yes

**Endocrine**

- Thirsty most of the time  no  yes
- Cold most of the time  no  yes
- Too hot most of the time  no  yes
- Unusually tired  no  yes
- Unusually jumpy or nervous  no  yes

**Psychologic**

- Often feel depressed  no  yes
- Cry easily  no  yes
- Are you hit by someone you love  no  yes
- Do you ever hit someone you love  no  yes
- In the past year, have you seriously considered or attempted suicide  no  yes
- Is there emotional abuse  no  yes
- Is there verbal abuse  no  yes

**Habits**

- Do you exercise for at least 20 minutes, 3 times a week  no  yes
- Do you smoke  no  yes
- How much do you smoke? \_\_\_\_\_ ppd
- Do you drink  no  yes
- Have you tried to cut down on your drinking  no  yes
- Are you annoyed when people ask you about your drinking  no  yes
- Do you ever feel guilty about your drinking  no  yes
- Do you ever take a morning eye opener  no  yes
- Do you usually wear a seatbelt  no  yes
- Do you use any medications or drugs  no  yes

**Comments:**

PMH & database reviewed and updated