HENDERSONVILLE OB GYN HEALTH HISTORY FORM TODAY'S DATE			
PATIENT NAME:_____ DATE OF BIRTH_____			
GASTROINTESTINAL	**YES**	**NO**	**NOTES**
Weight Loss			
Weight Gain			
Fatigue			
REPRODUCTIVE			
Itching			
Vaginal Discharge			
Irregular Bleeding			
Heavy Periods			
Bleeding Between Periods			
Painful Periods			
Painful Intercourse			
Night sweats/hot flashes			
BREAST			
Pain in Breast			
Nipple Discharge			
Masses/lumps			
CARDIO/PULMONARY			
Irregular Heartbeat			
Chest Pain			
Wheezing			
Shortness of Breath			
Chronic Cough			
GASTROINTESTINAL			
Diarrhea			
Bloody or Black Stool			
Nausea/Vomiting			
Constipation			
Heartburn			
URINARY			
Blood in Urine			
Painful Urination			
Leakage of Urine			
Incomplete Emptying			
MUSCULOSKELETAL			
Joint Swelling			
Chronic Pain			
MENTAL HEALTH			
Depression			
Crying Frequently			
Insomnia			
Anxiety			
HEMATOLOGIC/LYMPHATIC			
History of Blood Clots			
Bruises frequently			
Enlarged Lymph Nodes			
SKIN			
Worrisome Moles			
Rash			
ALLERGIES			
PLEASE LIST ANY ALLERGIES			