

Established Patient Summary

Name: _____ DOB: _____

Address: _____

Telephone: (H) _____ (W) _____ (C) _____

E-mail address: _____

Has your insurance changed since we last saw you _____ No _____ Yes

When was your last menstrual period? ___/___/___ _____ I am post menopausal

Please list any specific questions or concerns for Dr. Jacobs today:

Have you experienced any significant changes in your health, been hospitalized or undergone surgery since you were last seen here?

Have there been any changes in your family history?

Please let us know if you have been experiencing any of the following:

- Weight Change
- Fever/Chills
- Difficulty Sleeping
- Problems with your Eyes
- Hearing Loss
- Sinus Congestion
- Chest Pain/Palpitations
- Coughing/Wheezing/Difficulty Breathing
- Bloody Sputum
- Nausea/Vomitting
- Diarrhea
- Constipation
- Bloody Stools
- Frequent Urination
- Painful/Bloody Urine
- Leakage of Urine
- Bleeding Between Periods
- Heavy Vaginal Bleeding
- Vaginal Discharge
- Low Sex Drive/Sexual Dysfunction
- Recurrent Yeast Infections
- Painful Intercourse
- Pelvic Pain
- Skin Rashes
- Breast Pain/Discharge/Mass
- Seizures
- Fainting Episodes
- Mood Changes/Depression/Anxiety
- Heat/Cold Tolerance
- Excessive Thirst or Urination
- Hot Flashes
- Abnormal Bruising/Bleeding

Please List any allergies to medications:

Please list all medications below (attach additional pages if necessary):

Medication	Dosage	Frequency	Prescribed By

Please list all Vitamins/Supplements and Herbals below (attach additional pages if necessary):

Supplement	Dose	Frequency	Manufacturer

Is there anything else we should know for your appointment today?
