PATIENT INFORMATION

TODAY'S DATE:

<table>
<tr><td>PATIENT</td><td colspan="4">Mr.
Mrs.
Miss/Ms. Last First MI</td><td>CELL PHONE:

HOMEPHONE:</td></tr>
<tr><td colspan="2">Patient's Home Address</td><td>Street</td><td>City</td><td>State</td><td>Zip</td></tr>
<tr><td colspan="2">Social Security #</td><td>Date of Birth</td><td>Age</td><td>Sex</td><td>Driver's License #</td></tr>
<tr><td colspan="2">Patient's Employer</td><td>Work Address</td><td colspan="2">Work Phone:</td><td>Occupation:</td></tr>
<tr><td colspan="2">Spouse's Name</td><td colspan="3">Spouse's Employer (Name & Address)</td><td>Work Phone:</td></tr>
<tr><td colspan="6">Emergency Contact:(Local Relative or Friend)
Name: Address: Phone:</td></tr>
<tr><td colspan="6">E-MAIL ADDRESS:</td></tr>
</table>

REFERRED TO THIS OFFICE BY: ____

PURPOSE OF THIS VISIT: ____

NOTICE TO CONSUMERS

Medical doctors are licensed and regulated by the Medical Board of California

Contact Number :(800) 633-2322

Website: www.mbc.ca.gov

PLEASE READ & SIGN THE FOLLOWING:

I, ______________________________ , understand that Dr. Matlock is licensed
(Print your full name)

and regulated by the Board.

SIGN HERE: ______________________________ DATE: ________________

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FOR OFFICE USE ONLY

- ☐ NEW PATIENT
- ☐ ESTABLISHED PATIENT
- ☐ CONSULTATION
- ☐ REPORT SENT:

PATIENT INTAKE HISTORY

DATE:

If you are uncomfortable answering any questions, leave them blank; you can discuss them with your doctor or nurse.

GYNECOLOGIC HISTORY

	PHYSICIAN'S NOTES
LAST NORMAL MENSTRUAL PERIOD (FIRST DAY):	
AGE PERIODS BEGAN:	
LENGTH OF PERIODS (NUMBER OF DAYS OF BLEEDING):	
NUMBER OF DAYS BETWEEN PERIODS:	
ANY RECENT CHANGES IN PERIODS?	
ARE YOU CURRENTLY SEXUALLY ACTIVE?	
HAVE YOU EVER HAD SEX?	
NUMBER OF SEXUAL PARTNERS (LIFETIME):	
SEXUAL PARTNERS ARE: MEN WOMEN BOTH	
PRESENT METHOD OF BIRTH CONTROL:	
HAVE YOU EVER USED AN INTRAUTERINE DEVICE (IUD) OR BIRTH CONTROL PILLS?	
IF YES, FOR HOW LONG?	
WHEN WAS YOUR LAST PAP TEST?	
WHAT WAS THE RESULT?	
HAVE YOU EVER HAD AN ABNORMAL PAP TEST?	
DO YOU DO REGULAR BREAST SELF-EXAMINATIONS?	

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PATIENT INTAKE HISTORY *(Continued)*

OBSTETRIC HISTORY

	NUMBER		NUMBER		NUMBER
PREGNANCIES		ABORTIONS		MISCARRIAGES	
PREMATURE BIRTHS (<37 WEEKS)		LIVE BIRTHS		LIVING CHILDREN	

NO.	BIRTH DATE	WEIGHT AT BIRTH	BABY'S SEX	WEEKS PREGNANT	TYPE OF DELIVERY (VAGINAL, CESAREAN, ETC.)	COMPLICATIONS?
1.						
2.						
3.						
4.						

PHYSICIAN'S NOTES ON OBSTETRIC HISTORY:

CURRENT MEDICATIONS

(including hormones, vitamins, herbs, nonprescription medications)

DRUG NAME	DOSAGE	WHO PRESCRIBED	DRUG NAME	DOSAGE	WHO PRESCRIBED

FAMILY HISTORY

MOTHER: LIVING DECEASED CAUSE: AGE:

FATHER: LIVING DECEASED CAUSE: AGE:

SIBLINGS: NUMBER OF LIVING: NUMBER OF DECEASED: CAUSE(S)/AGE(S):

CHILDREN: NUMBER OF LIVING: NUMBER OF DECEASED: CAUSE(S)/AGE(S):

ILLNESS	YES	WHICH RELATIVE(S) AND AGE OF ONSET	PHYSICIAN'S NOTES
DIABETES			
STROKE			
HEART DISEASE			
BLOOD CLOTS IN LUNGS OR LEGS			
HIGH BLOOD PRESSURE			
HIGH CHOLESTEROL			
OSTEOPOROSIS (WEAK BONES)			
HEPATITIS			
HIV/AIDS			
TUBERCULOSIS			
BIRTH DEFECTS			
DRINKING OR DRUG PROBLEMS			
BREAST CANCER			
COLON CANCER			
OVARIAN CANCER			
UTERINE CANCER			
MENTAL ILLNESS/DEPRESSION			
ALZHEIMER'S DISEASE			
OTHER			

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PATIENT INTAKE HISTORY *(Continued)*

SOCIAL HISTORY

	YES	NO	PHYSICIAN'S NOTES
EVER SMOKED? PACKS PER DAY: YEARS:			
ALCOHOL: DRINKS PER DAY: DRINKS PER WEEK:			
RECREATIONAL DRUG USE:			
SEAT BELT USE:			
REGULAR EXERCISE: HOW LONG AND HOW OFTEN?			
DAIRY PRODUCT INTAKE/CALCIUM SUPPLEMENTS: QUANTITY:			
HEALTH HAZARDS AT HOME OR WORK?			
HAVE YOU BEEN SEXUALLY ABUSED, THREATENED, OR HURT BY ANYONE?			

PERSONAL PROFILE

SEXUAL ORIENTATION: HETEROSEXUAL HOMOSEXUAL BISEXUAL
MARITAL STATUS: MARRIED LIVING WITH PARTNER SINGLE WIDOWED DIVORCED
NUMBER OF LIVING CHILDREN:
NUMBER OF PEOPLE IN HOUSEHOLD:
SCHOOL COMPLETED: HIGHSCHOOL SOME COLLEGE/AA DEGREE COLLEGE GRADUATE DEGREE OTHER
CURRENT OR MOST RECENT JOB:
TRAVEL OUTSIDE THE U.S.? LOCATION:

PERSONAL PAST HISTORY OF ILLNESSES

MAJOR ILLNESSES	YES (DATE)	NO	NOT SURE	PHYSICIAN'S NOTES
ASTHMA				
PNEUMONIA/LUNG DISEASE				
KIDNEY INFECTIONS/STONES				
TUBERCULOSIS				
SEXUALLY TRANSMITTED DISEASE				
HIV/AIDS				
HEART ATTACK/PROBLEMS				
DIABETES				
HIGH BLOOD PRESSURE				
STROKE				
RHEUMATIC FEVER				
BLOOD CLOTS IN LUNGS OR LEGS				
EATING DISORDERS				
COLLAGEN VASCULAR DISEASE (LUPUS)				
CHICKENPOX				
CANCER				
REFLUX/HIATAL HERNIA/ULCERS				
DEPRESSION/ANXIETY				
ANEMIA				
BLOOD TRANSFUSIONS				
SEIZURES/CONVULSIONS/EPILEPSY				
BOWEL PROBLEMS				
GLAUCOMA				
CATARACTS				
ARTHRITIS/JOINT PAIN/BACK PROBLEMS				
BROKEN BONES				
HEPATITIS/YELLOW JAUNDICE/LIVER DISEASE				
THYROID DISEASE				

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PATIENT INTAKE HISTORY *(Continued)*

PERSONAL PAST HISTORY OF ILLNESSES *(Continued)*

MAJOR ILLNESSES	YES (DATE)	NO	NOT SURE	PHYSICIAN'S NOTES
GALLBLADDER DISEASE				
HEADACHES				
OTHER				

OPERATIONS/HOSPITALIZATIONS

REASON	DATE	HOSPITAL

INJURIES/ILLNESSES

TYPE	DATE	TYPE	DATE

IMMUNIZATIONS/TEST

	DATE		DATE
TETANUS-DIPHTHERIA BOOSTER		INFLUENZA VACCINE (FLU SHOT)	
HEPATITIS A VACCINE		HEPATITIS B VACCINE	
VARICELLA VACCINE		PNEUMOCOCCAL VACCINE	
MEASLES-MUMPS-RUBELLA (MMR) VACCINE		TUBERCULOSIS (TB) SKIN TEST: RESULT:	

PHYSICIAN'S NOTES:

REVIEW OF SYSTEMS

Please check (x) if any of the following symptoms apply to you now or since adulthood

	NOW	PAST	NOT SURE	PHYSICIAN'S NOTES
1. CONSTITUTIONAL				
WEIGHT LOSS	☐	☐	☐	
WEIGHT GAIN	☐	☐	☐	
FEVER	☐	☐	☐	
FATIGUE	☐	☐	☐	
CHANGE IN HEIGHT	☐	☐	☐	

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REVIEW OF SYSTEMS *(Continued)*

	NOW	PAST	NOT SURE	PHYSICIAN'S NOTES
2. EYES				
DOUBLE VISION	☐	☐	☐	
SPOTS BEFORE EYES	☐	☐	☐	
VISION CHANGES	☐	☐	☐	
GLASSES/CONTACTS	☐	☐	☐	
3. EAR, NOSE, AND THROAT				
EARACHES	☐	☐	☐	
RINGING IN EARS	☐	☐	☐	
HEARING PROBLEMS	☐	☐	☐	
SINUS PROBLEMS	☐	☐	☐	
SORE THROAT	☐	☐	☐	
MOUTH SORES	☐	☐	☐	
DENTAL PROBLEMS	☐	☐	☐	
4. CARDIOVASCULAR				
PAINFUL BREATHING	☐	☐	☐	
CHEST PAIN OR PRESSURE	☐	☐	☐	
DIFFICULTY BREATHING ON EXERTION	☐	☐	☐	
SWELLING OF LEGS	☐	☐	☐	
RAPID OR IRREGULAR HEARTBEAT	☐	☐	☐	
5. RESPIRATORY				
WHEEZING	☐	☐	☐	
SPITTING UP BLOOD	☐	☐	☐	
SHORTNESS OF BREATH	☐	☐	☐	
CHRONIC COUGH	☐	☐	☐	
6. GASTROINTESTINAL				
FREQUENT DIARRHEA	☐	☐	☐	
BLOODY STOOL	☐	☐	☐	
NAUSEA/VOMITING/INDIGESTION	☐	☐	☐	
CONSTIPATION	☐	☐	☐	
INVOLUNTARY LOSS OF GAS OR STOOL	☐	☐	☐	
7. GENITOURINARY				
BLOOD IN URINE	☐	☐	☐	
PAIN WITH URINATION	☐	☐	☐	
STRONG URGENCY TO URINATE	☐	☐	☐	
FREQUENT URINATION	☐	☐	☐	
INCOMPLETE EMPTYING	☐	☐	☐	
INVOLUNTARY/UNINTENDED URINE LOSS	☐	☐	☐	
URINE LOSS WHEN COUGHING OR LIFTING	☐	☐	☐	
ABNORMAL BLEEDING	☐	☐	☐	
PAINFUL PERIODS	☐	☐	☐	
PREMENSTRUAL SYNDROME (PMS)	☐	☐	☐	
PAINFUL INTERCOURSE	☐	☐	☐	
FIBROIDS	☐	☐	☐	
INFERTILITY	☐	☐	☐	
DES EXPOSURE	☐	☐	☐	
ABNORMAL VAGINAL DISCHARGE	☐	☐	☐	
8. MUSCULOSKELETAL				
MUSCLE WEAKNESS	☐	☐	☐	

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PATIENT INTAKE HISTORY *(Continued)*

REVIEW OF SYSTEMS *(Continued)*

	NOW	PAST	NOT SURE	PHYSICIAN'S NOTES
B. MUSCULOSKELETAL (Continued)				
MUSCLE OR JOINT PAIN	☐	☐	☐	
9a. **SKIN**				
RASH	☐	☐	☐	
SORES	☐	☐	☐	
DRY SKIN	☐	☐	☐	
MOLES	☐	☐	☐	
9b. **BREASTS**				
PAIN IN BREAST	☐	☐	☐	
NIPPLE DISCHARGE	☐	☐	☐	
LUMPS	☐	☐	☐	
10. **NEUROLOGIC**				
DIZZINESS	☐	☐	☐	
SEIZURES	☐	☐	☐	
NUMBNESS	☐	☐	☐	
TROUBLE WALKING	☐	☐	☐	
SEVERE MEMORY PROBLEMS	☐	☐	☐	
FREQUENT OR SEVERE HEADACHES	☐	☐	☐	
I 1. **PSYCHIATRIC**				
DEPRESSION OR FREQUENT CRYING	☐	☐	☐	
SEVERE ANXIETY	☐	☐	☐	
12. **ENDOCRINE**				
HAIR LOSS	☐	☐	☐	
HEAT/COLD INTOLERANCE	☐	☐	☐	
ABNORMAL THIRST	☐	☐	☐	
HOT FLASHES	☐	☐	☐	
13. **HEMATOLOGIC/LYMPHATIC**				
FREQUENT BRUISES	☐	☐	☐	
CUTS DO NOT STOP BLEEDING	☐	☐	☐	
ENLARGED LYMPH NODES (GLANDS)	☐	☐	☐	
14. **ALLERGIC/IMMUNOLOGIC**				
MEDICATION ALLERGIES	☐	☐	☐	
IF ANY, PLEASE LIST ALLERGY AND TYPE OF REACTION:				
OTHER ALLERGIES	☐	☐	☐	
PLEASE LIST ALLERGY AND TYPE OF REACTION:				

FORM COMPLETED BY: ☐ PATIENT ☐ OFFICE NURSE ☐ PHYSICIAN ☐ OTHER:

SIGNATURE OF PATIENT:

DATE REVIEWED BY PHYSICIAN WITH PATIENT:	PHYSICIAN SIGNATURE:

ANNUAL REVIEW OF HISTORY

DATE REVIEWED:	PHYSICIAN SIGNATURE:
DATE REVIEWED:	PHYSICIAN SIGNATURE:
DATE REVIEWED:	PHYSICIAN SIGNATURE:
DATE REVIEWED:	PHYSICIAN SIGNATURE:

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