INTERVAL HISTORY

Date: _____/_____/_____ **Name:** _____

DOB: _____ **Age:** _____ **Marital Status:** _____

Home Phone: _____ **Cell Phone:** _____

****PLEASE HELP KEEP OUR OFFICE UP TO DATE BY ANSWERING THE FOLLOWING QUESTIONS****

1. LOCAL PHARMACY, NAME & PHONE:_____
2. MAIL IN PHARMACY, NAME & PHONE:_____
3. DATE OF LAST MENSTRUAL CYCLE: _____/_____/_____ WAS CYCLE NORMAL? YES / NO
4. WHAT WAS THE DATE OF YOUR LAST MAMMOGRAM? _____/_____/_____
5. WHERE DID YOU HAVE YOUR LAST MAMMOGRAM? _____
6. WHO IS YOUR PRIMARY CARE PHYSICIAN? _____
7. DO YOU SEE ANY OTHER PHYSICIANS? YES / NO
   a. IF YES, PLEASE LIST:_____
8. HAVE YOU HAD ANY SERIOUS ILLNESSES, OPERATIONS, INJURIES, OR HOSPITALIZED SINCE YOUR LAST VISIT IN OUR OFFICE? YES / NO
   a. IF YES, PLEASE EXPLAIN:_____
9. HAS ANY FAMILY HEALTH HISTORY CHANGED SINCE YOUR LAST VISIT IN OUR OFFICE? YES / NO
   a. IF YES, PLEASE EXPLAIN:_____
10. HAVE YOUR MEDICATIONS CHANGED SINCE YOUR LAST VISIT IN OUR OFFICE? YES / NO
    a. IF YES, PLEASE EXPLAIN:_____
11. HAVE YOU CHANGED ANY HABITS (SMOKING, DRINKING, OR DRUG USE) OR OCCUPATION SINCE YOUR LAST VISIT IN OUR OFFICE? YES / NO
    a. IF YES, PLEASE EXPLAIN:_____

PLEASE CONTINUE ON BACK SIDE

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