

Jessica Davis MD

The New Mom's Family Doctor

781 Hudson Avenue | PO Box 173 | Stillwater, NY 12170

phone: 877.664.6116 | email: DrJess@jessicadavismd.com

FAMILY HISTORY

Please check any family members who have the following health problems:

	Father	Mother	Brother	Sister	Grandparent	Other
Age (if still alive)						
OR Age at death						
Diabetes						
Glaucoma						
Colon Cancer						
Breast/Ovarian Cancer						
Other Cancer						
Heart attack						
Angina						
Stroke						
High blood pressure						
High cholesterol						
Alcoholism						
Drug Abuse						
Depression						
Other Mental Illness						
Suicide						
Obesity						
Asthma						
Eczema/Psoriasis						
Food Allergies						
AutoImmune Diseases						
Genetic Disorders						
Other health issues						
Other health issues						

Do you have a Family History of:

Heart Attack in a sister or mother before the age of 65 years of age?

Yes No

Heart Attack in a brother or father before the age of 55 years of age?

Yes No

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REVIEW OF SYSTEMS

Check the Yes or No column for any symptoms that are CURRENTLY a problem for you.

Yes	No	General	Yes	No	Dermatology	Yes	No	GI
		Fever			Rash			Nausea
		Chills			Itching			Vomiting
		Sweats			Dryness			Diarrhea
		Fatigue			Suspicious moles			Constipation
		Decreased appetite	Yes	No	Musculoskeletal			Change in bowel habits
		Weakness			Back pain			Abdominal pain
		Just don't feel well			Joint pain			Black or tar-like stools
		Weight loss			Joint swelling			Bloody stools
		Sleep problems			Muscle cramps			Gas/Bloating
Yes	No	Eyes			Muscle weakness			Indigestion/Heartburn
		Blurred vision			Stiffness			Difficulty Swallowing
		Double vision			Arthritis			Feel full early
		Eye discharge			Sciatica	Yes	No	Neurology
		Vision change or loss			Restless legs			Paralysis
		Eye pain			Leg pain at night			Unusual sensations
		Sensitivity to light	Yes	No	Psychiatric			Seizures
Yes	No	Ears/Nose/Throat			Depression			Tremors
		Earache			Anxiety			Vertigo/Dizziness
		Ear discharge			Memory loss			Frequent falls
		Tinnitus/Ringing			Suicidal Thoughts			Frequent headaches
		Decreased hearing			Hallucinations			Difficulty walking
		Nasal congestion			Paranoia	Yes	No	Cardiovascular
		Hoarseness			Phobia/Fear of things			Chest pains
		Nosebleeds			Confusion			Palpitations
Yes	No	Respiratory			Trouble concentrating			Skipped beats
		Cough	Yes	No	Allergy			Syncope/Fainting
		Difficulty breathing			Hives			Difficulty breathing
		• at rest			Frequent infections			• on exertion
		Excessive sputum			Itchy eyes			• when lying down
		Wheezing	Yes	No	Endocrinology			Shortness of breath at night
		Coughing up blood			Constantly cold			Swelling in your legs or ankles
		Pain with deep breath			Constantly hot			
Yes	No	Hematology			Constantly thirsty	Yes	No	Other?
		Unusual bruising			Constantly hungry			
		Unusual bleeding			Unusual weight change			
		Swollen lymph nodes						

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REVIEW OF SYSTEMS (continued)

Yes	No	Reproductive	Yes	No	Reproductive	Yes	No	Urinary
		Vaginal bleeding			Pelvic pain			Incontinence/urine leak
		Missed periods			Infertility			Painful urination
		Heavy periods			Vaginal dryness			Blood in the urine
		PMS			Hot Flashes			Frequent urination
		Vaginal discharge			Decreased libido			
		Genital sores			Painful intercourse			

GYNECOLOGIC HISTORY

OBSTETRIC HISTORY: Provide number of each in the box.

Pregnancies Caesarean Vaginal Deliveries
 Miscarriage Abortion Living Children

Check any that apply:

Postpartum Depression Toxemia/Exclampsia Gestational Diabetes
 Baby over 8 pounds Breast Feeding (how long?) _____

MENSTRUAL HISTORY:

Age at first period: _____ Menses Frequency: _____ Length: _____ Pain: **Yes No**

Has your period ever skipped? **Yes No** For how long? _____

Last Menstrual Period: _____

Do you currently use hormonal contraception such as: (*please circle*) **Birth Control Pills / Patch / NuvaRing**

How long have you been on it? _____

Do you use other contraception? **Yes No** **Condom / Diaphragm / IUD / Partner Vasectomy**

Are you in Menopause? **Yes No Not Sure**

Age at menopause? _____

IMMUNIZATIONS

	Yes	No	Date		Yes	No	Date
Hepatitis B				Hepatitis A			
Tetanus				Influenza			
"Pneumonia Shot"				Gardasil			
Varicella shot (chickenpox)				MMR			
OR have you had Chickenpox?				Shingles			

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PREVENTIVE SCREENING and DIAGNOSTIC TESTS

Check if done, then provide date (at least month and year) if known.

Done	Test	Date
	Full Physical Exam	
	Bone Density Scan	
	Mammogram	
	Pap Smear	
	Colonoscopy	
	EKG	
	Stool test for blood	
	Cholesterol	

Done	Test	Date
	MRI	
	CT Scan	
	Upper Endoscopy	
	Upper GI series	
	Ultrasound	
	X-rays	
	Cardiac Stress Test	

Height: _____ Weight: _____

Do you ride a motorcycle? **Yes No**
 Bicycle? **Yes No**
 Ski/Snowboard? **Yes No**
 Skateboard? **Yes No**

If yes, do you wear a helmet? **Yes No**

Do you have regular dental check-ups? **Yes No**
 Do you have a smoke detector at home? **Yes No**
 Do you always wear a seatbelt? **Yes No**

When was it last checked? _____

SOCIAL HISTORY

Marital Status: (please circle) **Single / Married / Divorced / Gay/Lesbian / Long Term Partnership**

List children, if any. Include last names if different than your own.

Child's Name	Age	Gender

Does anyone else live in Household? Total number _____ Names: _____

Their Employment/Occupation: _____

Resources for emotional support? **Spouse / Family / Friends / Religious or Spiritual / Pets / Other:**

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SOCIAL HISTORY (continued)

How well have things been going for you?	Very Well	Fine	Poorly	Does Not Apply	Comments
Overall					
In school					
In your job					
In your social life					
With close friends					
With sex					
With your attitude					
With your children					
With your parents					
With your partner					

Do you feel significantly less vital than you did a year ago?	Yes	No
Are you happy?	Yes	No
Do you feel your life has meaning and purpose?	Yes	No
Do you like the work you do?	Yes	No
Have you ever experienced major losses in your life?	Yes	No
Do you spend the majority of your time and money to fulfill responsibilities and obligations?	Yes	No
Would you describe your experience as a child in your family as happy and secure?	Yes	No
Do you feel you have an excessive amount of stress in your life?	Yes	No
Do you feel you can easily handle the stress in your life?	Yes	No
Do you believe stress is currently reducing the quality of your life?	Yes	No
Daily Stressors: Rate on scale of 1-10 with 1 being little or no stress, 10 being the maximum)		
Work _____	Family _____	Social _____
Finances _____	Health _____	Other _____
Have you ever sought counseling? ?	Yes	No
Are you currently in therapy?	Yes	No
Do you practice meditation or relaxation techniques? If so, how often? _____	Yes	No
Circle all that apply: Yoga / Meditation / Imagery / Breathing / Tai Chi / Prayer / Other: _____		
Have you ever been abused, a victim of a crime, or experienced a significant trauma?	Yes	No
Have you had any recent significant changes in your life?	Yes	No
Are you having financial hardships?	Yes	No
Any particular stressors in your life right now?	Yes	No
Comments:		

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SOCIAL HISTORY (continued)

Over the last 2 weeks, how often have you been bothered by any of the following problems? Check the appropriate box.

	Not at all	Several days	More than half	Nearly every day
	0	1	2	3
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling asleep, staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down				
Trouble concentrating on things such as reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual				
Thinking that you would be better off dead or that you want to hurt yourself in some way				

If you checked off any problems above, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? *(circle one)*

Not Difficult

Somewhat Difficult

Very Difficult

Extremely Difficult

Because violence is so common in many people's lives, I've begun to ask all my patients about it.

Have you ever been in an abusive relationship?	Yes	No
Does your partner ever hit you, hurt you, or threaten you in any way?	Yes	No
Are you ever frightened of your partner?	Yes	No
Has anyone ever hit you, hurt you, or threatened you in the past?	Yes	No

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DIET / SLEEP / EXERCISE

How many caffeinated drinks do you have per day? (circle)	0 1 2 3 4+
How many servings of soda do you drink per day? (circle)	0 1 2 3 4+
Do you use artificial sweeteners?	Yes No
How many ounces of water do you drink in a day? (1 glass ~ 8 oz, 1 quart = 32 oz, 1 gallon = 128 oz)	_____
How many meals do you eat out per week?	0 1 2 3 4+
How much prepared food do you eat? (not home-made) - give approximate percent and list main foods:	_____
If you are on a special diet, please explain: _____	
Are you happy with your weight?	Yes No
Amount and type of dairy products you consume on an average day:	_____
List breakfast, lunch, dinner and snacks for the last 24 hours:	
Average number of hours you sleep per night: _____	
Do you have trouble falling asleep?	Yes No
Do you feel rested upon awakening?	Yes No
Do you have problems with insomnia?	Yes No
Do you snore?	Yes No
Do you use sleeping aids? If yes, explain:	Yes No
Do you exercise regularly? If yes, how many times per week: _____ for _____ minutes.	Yes No
Type of exercise: Stretching Cardio/Aerobic Strength Other	_____
Rate your level of motivation for including exercise in your life:	Low Medium High
List any barriers that prevent you from exercising:	

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RISK BEHAVIORS

Have you ever used tobacco products regularly? **Yes** **No** If yes, please continue below:

Year Started	Type	Amount	Still Use?		Describe any Quit Attempts
_____	Cigarettes	___pack/day	Yes	No	_____
_____	Cigars	___#/week	Yes	No	_____
_____	Other	_____	Yes	No	_____

Do you currently use other recreational drugs or substances that could affect your health? **Yes** **No**

Have you ever used IV or inhaled recreational drugs?

Have you been exposed to any Toxic Substances, such as asbestos, DES, radiation, chemicals? **Yes** **No**

If yes, please explain:

HIV/AIDS Risk:

Certain activities and medical issues can increase your risk for becoming infected with the HIV/AIDS virus.

- 1) Sharing injection drug needles and syringes or "works."
- 2) Having sex without a condom with someone who had HIV/AIDS.
- 3) Having a sexually transmitted disease, like chlamydia or gonorrhea.
- 4) Receiving a blood transfusion or a blood clotting factor between 1978 and 1985.
- 5) Having sex with someone who has done any of those things.

Have any of these activities or problems ever applied to you? **Yes** **No**

Alcohol Use: Circle the beverages you regularly consume and list the amount you drink per DAY on average:

Beer:	0	Less than 1	1	2	3	4	More than 4
Wine:	0	Less than 1	1	2	3	4	More than 4
Hard liquor:	0	Less than 1	1	2	3	4	More than 4
Other:	0	Less than 1	1	2	3	4	More than 4

Previous Alcohol intake? **(Mild Moderate High)** **Yes** **No**

Have you ever been told you should cut down your alcohol intake? **Yes** **No**

Do you get annoyed when people ask you about your drinking? **Yes** **No**

Do you ever feel guilty about your alcohol consumption? **Yes** **No**

Do you ever take an eye-opener? **Yes** **No**

Do you notice a tolerance to alcohol (can you "hold" more than others)? **Yes** **No**

Have you ever been unable to remember what you did during a drinking episode? **Yes** **No**

Have you ever been arrested or hospitalized because of drinking? **Yes** **No**

Have you ever thought about getting help to control or stop your drinking? **Yes** **No**

Do you get into arguments or physical fights when you have been drinking? **Yes** **No**

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READINESS ASSESSMENT

Rate on a scale of: 5 (very willing) to 1 (not willing).

In order to improve your health, how willing are you to:

Significantly modify your diet	5	4	3	2	1
Take several nutritional supplements each day	5	4	3	2	1
Keep a record of everything you eat each day	5	4	3	2	1
Modify your lifestyle (e.g., work demands, sleep habits)	5	4	3	2	1
Practice a relaxation technique	5	4	3	2	1
Engage in regular exercise	5	4	3	2	1
Have periodic labs to assess your progress	5	4	3	2	1

Comments: _____

ORGAN DONATION: Do you want to be an Organ Donor? **Yes** **No** **Don't Know**

ADVANCED DIRECTIVES: Do you have an advanced directive or living will: **Yes** **No**

CONSULTANTS

Please list any current specialists involved in your care:

Specialty			
Name			
Practice			
Phone			
Fax			
Address 1			
Address 2			
Specialty			
Name			
Practice			
Phone			
Fax			
Address			
Address 2			

To the best of my knowledge, this is a complete and accurate statement of my health:

Signature: _____ Date: ____ - ____ - ____