

**Markle and Hinshaw Gynecology**

722 Highlands Road  
Franklin, North Carolina 28734  
828-342-3766

Please circle or describe all current and ongoing problems. We will ask you for the details.

If you have no current or ongoing medical problems, check here: None

**Constitutional**     Chills             Fatigue     Fever  
  
 Weight change     Other \_\_\_\_\_

**Cancer**             Breast     Uterus     Cervix  
  
 Ovary             Other \_\_\_\_\_

**Eyes**             Blurred vision     Pain     Light intolerance     Other \_\_\_\_\_

**E/N/T**             Pain     Deafness     Congestion  
  
 Bleeding     Teeth             Other \_\_\_\_\_

**Cardiovascular**     Chest pain     Irregular pulse     Fainting  
  
 Swelling     Cholesterol     Other \_\_\_\_\_

**Respiratory**    **Cough**     Breathing problem     Asthma     Steroid use     Other \_\_\_\_\_

**Gastrointestinal**     Abdominal pain     Heartburn     Constipation     Diarrhea  
  
 Stool changes     Other \_\_\_\_\_

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**Musculoskeletal**     Joint pain     Back pain     Muscle pain     Fracture  
  
 Steroid use     Other\_\_\_\_\_

**Urologic**             Frequency     Urgency     Control loss  
  
 Blood             Other\_\_\_\_\_

**Gynecologic**             Bleeding     Pain     Discharge     Itch     Other\_\_\_\_\_

**Breasts**     Tenderness     Pain     Lumps     Discharge     Other\_\_\_\_\_

**Skin**     New moles     Rash     Itch     Fragile     Steroid use     Other\_\_\_\_\_

**Neurological**     Dizziness     Weakness     Numbness     Headaches             Other\_\_\_\_\_

**Blood**     Bleeding     Bruising     Other\_\_\_\_\_

**Endocrine**     Thirst     Excessive hunger     Chronic vaginitis     Other\_\_\_\_\_

**Immunologic**     Allergies     HIV exposure     Immunosupression     Other\_\_\_\_\_

**Psychological**     Anxiety     Depression     Bipolar diagnosis     Other\_\_\_\_\_

**Other** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**Have you had a mammogram?**       Y    N    Date \_\_\_\_\_    Location \_\_\_\_\_

**Have you had a bone density test (DXA)?**    Y    N    Date \_\_\_\_\_    Location \_\_\_\_\_

**Have you had a Pap smear?**       Y    N    Date \_\_\_\_\_    Location \_\_\_\_\_

**List any recent X-rays, CT-scans, MRIs**

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