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**Obstetrics • Gynecology • Infertility**

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## Appointment Worksheet

Patient Name \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Last First MI

Present Age: \_\_\_\_\_ Last Menstrual Period: \_\_\_\_\_ Normal? \_\_\_\_\_

Please check if you have any of the following:

	In the PAST	Now		In the PAST	Now
1. Severe headache	<input type="checkbox"/>	<input type="checkbox"/>	23. Change in bowel habits	<input type="checkbox"/>	<input type="checkbox"/>
2. Glasses	<input type="checkbox"/>	<input type="checkbox"/>	24. Burning when urinating	<input type="checkbox"/>	<input type="checkbox"/>
3. Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	25. Urinating 3 or more time/ night	<input type="checkbox"/>	<input type="checkbox"/>
4. Serious ear problems	<input type="checkbox"/>	<input type="checkbox"/>	26. Loss of urine when coughing	<input type="checkbox"/>	<input type="checkbox"/>
5. Dentures	<input type="checkbox"/>	<input type="checkbox"/>	27. Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>
6. Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	28. Venereal disease (GC, herpes, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
7. High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	29. Bothersome vaginal discharge	<input type="checkbox"/>	<input type="checkbox"/>
8. Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	30. Painful periods	<input type="checkbox"/>	<input type="checkbox"/>
9. Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	31. Heavy menstrual periods	<input type="checkbox"/>	<input type="checkbox"/>
10. Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	32. Breast biopsy	<input type="checkbox"/>	<input type="checkbox"/>
11. Excessive swelling of ankles	<input type="checkbox"/>	<input type="checkbox"/>	33. Pelvic infection	<input type="checkbox"/>	<input type="checkbox"/>
12. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	34. Trouble with sex	<input type="checkbox"/>	<input type="checkbox"/>
13. Coughing up blood	<input type="checkbox"/>	<input type="checkbox"/>	35. Abnormal pap smear	<input type="checkbox"/>	<input type="checkbox"/>
14. Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	36. Excessive weight loss/gain	<input type="checkbox"/>	<input type="checkbox"/>
15. Prolonged nausea & vomiting	<input type="checkbox"/>	<input type="checkbox"/>	37. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
16. Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	38. Hypothyroidism/hyperthyroidism	<input type="checkbox"/>	<input type="checkbox"/>
17. Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	39. Psychiatric care	<input type="checkbox"/>	<input type="checkbox"/>
18. Severe abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	40. Severe depression	<input type="checkbox"/>	<input type="checkbox"/>
19. Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	41. Blood clots	<input type="checkbox"/>	<input type="checkbox"/>
20. Black stool	<input type="checkbox"/>	<input type="checkbox"/>	42. Convulsions	<input type="checkbox"/>	<input type="checkbox"/>
23. Gall bladder disease	<input type="checkbox"/>	<input type="checkbox"/>	43. Painful joints	<input type="checkbox"/>	<input type="checkbox"/>
21. Blood in stool	<input type="checkbox"/>	<input type="checkbox"/>	44. Leg cramps	<input type="checkbox"/>	<input type="checkbox"/>
22. Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	45. Broken bones	<input type="checkbox"/>	<input type="checkbox"/>

Any medication you are presently taking? \_\_\_\_\_

Allergies to medications: \_\_\_\_\_

FURTHER HISTORY: \_\_\_\_\_

Physical Exam v/s:

T: \_\_\_\_\_ P: \_\_\_\_\_ R: \_\_\_\_\_ HT: \_\_\_\_\_ WT: \_\_\_\_\_ BP: \_\_\_\_\_ UA: \_\_\_\_\_

Further History by Nurse or Doctor:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_