Medical History *Date:* / /

Name _____ Age _____ Birthdate ___/___/___

Address _____ Sex: ☐ M ☐ F

_____ Home phone _____

_____ Work phone _____

Occupation _____ Emergency contact _____

Phone _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If married, spouse's name _____

Children's names and ages _____

Allergies to Medications, X-Ray Dyes, or Other Substances ☐ No ☐ Yes

(If yes, please list name of medicine and type of reaction):

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Past Medical History & Review of Systems

Please circle if you have had problems with or are presently complaining of any of the following:

1. High blood pressure
2. Diabetes
3. Cancer
4. Heart disease
5. Chest pain/chest tightness
6. Shortness of breath
7. Swollen ankles
8. Palpitations
9. Lightheadedness
10. Frequent urination
11. Rheumatic fever
12. Asthma
13. Bronchitis
14. Pneumonia
15. Persistent cough
16. T.B.
17. Hay fever
18. Abdominal discomfort
19. Indigestion
20. Nausea
21. Vomiting
22. Constipation
23. Diarrhea
24. Blood in stool
25. Ulcers
26. Change in bowel habits
27. Unexplained weight gain/loss
28. Hemorrhoids
29. Gall bladder disease
30. Colitis
31. Hepatitis or jaundice
32. Thyroid disease
33. Head or neck radiation
34. Headache
35. Kidney diseases
36. Kidney stones
37. Difficulty urinating
38. Arthritis
39. Low back problems
40. Skin diseases
41. Blood disorders
42. Venereal diseases
43. Anxiety
44. Depression
45. Anemia
46. Alcohol abuse
47. Drug abuse
48. Gout
49. _____
50. _____

_____

_____

_____

_____

_____

_____

_____

_____

Gynecologic and Obstetric History

Age at onset of periods: _____ Frequency: _____ Length of period: _____

Pregnancies: _____ Births: _____ Miscarriages: _____

Prolonged or abnormal bleeding: ☐ No ☐ Yes (Please describe): _____

Leakage of urine: ☐ No ☐ Yes (Please describe): _____

Pelvic pain: ☐ No ☐ Yes (Please describe): _____

Abnormal discharge: ☐ No ☐ Yes (Please describe): _____

History of abnormal Pap smear: ☐ No ☐ Yes (Type of treatment): _____

Patient Name: *Date:* / /

Please List and Supply the Dates of:

Operations: _____ _____ _____

_____ _____ _____

Hospitalizations other than for surgery: _____ _____

_____ _____ _____

Immunization history—have you had:

Hepatitis B? ☐ No ☐ Yes When? _____

Other? _____ ☐ No ☐ Yes When? _____

Pneumovax immunization? ☐ No ☐ Yes When? _____

Flu immunization? ☐ No ☐ Yes When? _____

Tetanus immunization? ☐ No ☐ Yes When? _____

When was your last:

Pap smear? _____ Breast exam? _____ Stool check for blood? _____

Mammogram? _____ Cholesterol check? _____ Prostate exam? _____

Family History

Has any member of your family (including parents, grandparents, and siblings) ever had the following?

Illness	Which family members?	Approx. age when diagnosed
Cancer (describe type)		
Hypertension (high blood pressure)		
Heart disease		
Diabetes		
Strokes		
Mental disease (anxiety, depression, etc.)		
Drug or alcohol addiction		
Glaucoma		
Bleeding diseases		
Other: _____		

Medications (Prescription, Over-the-Counter, Vitamins, Herbs, etc.)

Drug name	Dose	Drug name	Dose

Prevention

Do you wear seatbelts?	☐ No	☐ Yes	If no, why not? _____
Do you wear a bike helmet?	☐ No	☐ Yes	☐ N/A
Do you smoke?	☐ No	☐ Yes	If yes, how many packs per day? _____
Do you drink alcoholic beverages?	☐ No	☐ Yes	If yes, how much per week? _____
Do you drink coffee?	☐ No	☐ Yes	If yes, how many cups per day? _____
Do you drink tea?	☐ No	☐ Yes	If yes, how many cups per day? _____
If there is a gun in your home, is it out of children's reach and unloaded?	☐ No	☐ Yes	☐ N/A
Do you use drugs? (marijuana, cocaine, crack, etc.)	☐ No	☐ Yes	If yes, explain: _____
Have you ever engaged in any activity which has put you at risk of getting AIDS?	☐ No	☐ Yes	If yes, explain: _____
Do you wish to be tested for AIDS?	☐ No	☐ Yes	
Have you ever worked with chemicals, paints, asbestos, or other hazardous material?	☐ No	☐ Yes	If yes, explain: _____
Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, bruised) by your partner?	☐ No	☐ Yes	
Do you ever feel afraid of your partner?	☐ No	☐ Yes	
Do you have a "living will"?	☐ No	☐ Yes	
Do you have a donor card?	☐ No	☐ Yes	

Method of birth control? _____