

Medical History

Date: _____

Patient Name: _____ Age: _____ Birthdate: ____/____/____ Sex: M F

Address: _____

Home phone: _____ Work phone: _____

Occupation: _____

Single Married Divorced Widowed Separated If married, spouse's name: _____

Children's names and ages: _____

Emergency contact: _____ Phone: _____

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

If yes, please list name of medicine and type of reaction.

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Past Medical History & Review of Systems

Please check if **YOU** have had problems with or are presently complaining of any of the following.

- | | | | | |
|---|---|---|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Hepatitis or jaundice | <input type="checkbox"/> Blood disorders |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma | <input type="checkbox"/> Constipation | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Venereal diseases |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Head or neck radiation | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Headache | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Chest pain/chest tightness | <input type="checkbox"/> Persistent cough | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> T.B. | <input type="checkbox"/> Change in bowel habits | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Alcohol abuse |
| <input type="checkbox"/> Swollen ankles | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Unexplained weight gain/loss | <input type="checkbox"/> Difficulty urinating | <input type="checkbox"/> Drug abuse |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Abdominal discomfort | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Lightheadedness | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Gall bladder disease | <input type="checkbox"/> Low back problems | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Nausea | <input type="checkbox"/> Colitis | <input type="checkbox"/> Skin diseases | <input type="checkbox"/> _____ |

Gynecologic & Obstetric History

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

Pregnancies: _____ Births: _____ Miscarriages: _____

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

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

Pelvic Pain: Yes No (Please describe): _____

Abnormal discharge: Yes No (Please describe): _____

History of abnormal Pap smear: Yes No (Please describe): _____

Please list and supply the dates of:

Operations: _____

 Hospitalizations other than for surgery: _____

IMMUNIZATION HISTORY – Have you had:

Hepatitis B? Yes No When? _____ Tetanus immunization? Yes No When? _____
 Pneumovax immunization? Yes No When? _____ TB Test? Yes No When? _____
 Flu immunization? Yes No When? _____ Other? _____ Yes No 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
<input type="checkbox"/> Cancer (type: _____)	_____	_____
<input type="checkbox"/> Hypertension (high blood pressure)	_____	_____
<input type="checkbox"/> Heart disease	_____	_____
<input type="checkbox"/> Diabetes	_____	_____
<input type="checkbox"/> Strokes	_____	_____
<input type="checkbox"/> Mental disease (anxiety, depression, etc.)	_____	_____
<input type="checkbox"/> Drug or alcohol addiction	_____	_____
<input type="checkbox"/> Glaucoma	_____	_____
<input type="checkbox"/> Bleeding disease	_____	_____
<input type="checkbox"/> Other: _____	_____	_____

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

Drug Name	Dose	Drug Name	Dose
_____	_____	_____	_____
_____	_____	_____	_____

Prevention

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