Medical History

Date _____

Name _____ Age _____ Birthdate _____

Address _____ Sex ☐ Male ☐ Female

_____ 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 and Review of Systems

Please check off if **you** have had any problems with or are presently experiencing any of the following:

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Chest pain/chest tightness
- ☐ Shortness of breath
- ☐ Swollen ankles
- ☐ Palpitations
- ☐ Lightheadedness
- ☐ Frequent urination
- ☐ Rheumatic fever
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Persistent cough
- ☐ T.B.
- ☐ Hay fever
- ☐ Abdominal discomfort
- ☐ Indigestion
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in stool
- ☐ Ulcers
- ☐ Change in bowel habits
- ☐ Unexplained weight gain/loss
- ☐ Hemorrhoids
- ☐ Gall Bladder disease
- ☐ Colitis
- ☐ Hepatitis or jaundice
- ☐ Thyroid disease
- ☐ Head or neck radiation
- ☐ Headache
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Difficulty urinating
- ☐ Arthritis
- ☐ Low back problems
- ☐ Skin diseases
- ☐ Blood disorders
- ☐ Venereal diseases
- ☐ Anxiety
- ☐ Depression
- ☐ Anemia
- ☐ Alcohol abuse
- ☐ Drug abuse
- ☐ Gout
- ☐ Impotence or Erectile Dysfunction
- ☐ Other

_____

_____

_____

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_____

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 (Please describe) _____

This information is for use by your physician as part of your confidential medical record.

Please continue on the next page

Medical History

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?	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	Drug Name	Dose

Prevention

Do you wear seat belts? ☐ Yes ☐ No If no, why not? _____

Do you wear a bike helmet? ☐ Yes ☐ No ☐ N/A

Do you exercise regularly? ☐ Yes ☐ No If yes, type, duration and number of times per week? _____

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? _____

If there is a gun in your home, do you keep it unloaded and out of children's reach? ☐ 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 materials? ☐ 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 ☐ N/A

Do you have a "living will"? ☐ Yes ☐ No

Do you have a donor card? ☐ Yes ☐ No

Method of birth control? _____

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