MEDICAL HISTORY

Name____________________ Age ______ Birthdate ____/____/____

Address____________________ Sex M F SS# ____/____/____

Home Phone ____________________

Work/Cell phone ____________________

Employer____________________ Emergency Contact ____________________

Phone ____________________

Single Married Divorced Widowed Separated

If married, spouse's name ____________________

Minor Childrens' names, birthdates and SS#s :

Allergies to Medications, X-Ray dye, or Other substances No Yes
(If yes, please name medication and type of reaction)

Past Medical History & Review of Systems (Please circle if you've had or are complaining of any of the following):

High blood pressure	Bronchitis	Change in bowel habits	Arthritis
Diabetes	Pneumonia	Unexplained weight loss/gain	Low back problems
Cancer	Persistent cough	Hemorrhoids	Skin diseases
Heart disease	Tuberculosis	Gallbladder disease	Blood disorders
Chest pain/chest tightness	Hay fever	Colitis	Venereal disease
Shortness of breath	Abdominal pain	Hepatitis or jaundice	Anxiety
Swollen ankles	Indigestion	Thyroid disease	Depression
Palpitations	Nausea	Head or neck radiation	Anemia
Lightheadedness	Vomiting	Headache	Alcohol abuse
Frequent urination	Constipation	Kidney disease	Drug abuse
Rheumatic fever	Diarrhea	Kidney stones	Gout
Asthma	Blood in stool	Difficulty urinating	Sleep disturbance
Nicotine abuse			

Gynecologic & 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) __________

Method of birth control ____________________

(OVER)

Please list and supply the dates of:

Operations ______________________________
____
____

Hospitalizations other than for surgery ______________________________
____

Immunization history – have you had? (If yes, please list the date)

Pneumovax	No	Yes ________	Hepatitis B	No	Yes ________
Flu vaccine	No	Yes ________	Tetanus	No	Yes ________

Other ______________

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?:
(If answer is yes, describe who had it and age when diagnosed)

Cancer (describe type) ______________
Heart disease ______________
Stroke ______________
Glaucoma ______________
Mental disease ______________
(anxiety/depression)

High blood pressure ______________
Diabetes ______________
Drug/Alcohol addiction ______________
Bleeding diseases ______________
Other ______________

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

Drug Name Dose
____
____
____

Prevention

Do you wear seatbelts	No	Yes	If no, why not? ________
Do you wear bike helmet?	No	Yes	N/A
Do you smoke?	No	Yes	How many packs a day? ________
Do you drink alcoholic beverages?	No	Yes	How many per week? ________
Do you drink coffee?	No	Yes	How many cups a day? ________
Do you drink tea?	No	Yes	How many cups a day? ________
Is there a gun in your home, is it out of childrens' reach and unloaded?	No	Yes	N/A
Do you use drugs? (marijuana, cocaine, crack,etc.)	No	Yes	Explain________
Have you ever engaged in any activity which has put you at risk of getting AIDS?	No	Yes	Explain________
Do you wish to be tested for AIDS?	No	Yes	
Have you ever worked with chemicals, paint, asbestos or other hazardous materials?	No	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	