

Medical History

Date: / /

Name: _____ Sex: M F / Age: ___ Birthdate: _____
Address: _____ Home Phone: _____

Work Phone: _____

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

Immunization History – Have you had:

Hepatitis B: No Yes When? _____ Tetanus: No Yes When? _____
Pneumovax Immunization: No Yes When? _____ Other: No Yes When? _____
Flu Immunization: No Yes When? _____

When Was Your Last:

Pap smear: _____ Breast exam: _____ Stool check for blood: _____
Mammogram: _____ Cholesterol Check: _____ Prostate exam: _____

Patient Name (*print*): _____ DOB: _____

Gynecologic & Obstetric History

- 1. Age at onset of periods: _____ Frequency: _____ Length of period: _____
- 2. How many pregnancies?: _____ How many births?: _____ Any miscarriages?: _____
- 3. Prolonged or abnormal bleeding: No Yes (*please describe*): _____
- 4. Leakage of urine: No Yes (*please describe*): _____
- 5. Pelvic pain: No Yes (*please describe*): _____
- 6. Abnormal discharge: No Yes (*please describe*): _____
- 7. History of abnormal pap smear: No Yes (*please describe*): _____

Please List and Supply the Dates for the Following:

Operations: _____

Other Hospitalizations: _____

Family History – Has any family member (parents, grandparents, siblings) ever had the following?

Type & Relationship

When diagnosed

Cancer: _____

Hypertension: _____

Heart Disease: _____

Diabetes: _____

Strokes: _____

Mental Illness (*depression, etc*): _____

Drug / Alcohol Addiction: _____

Do you smoke ? No Yes *If yes, how many packs per day?* _____

Do you drink alcohol ? No Yes *If yes, how much per day?* _____

Do you drink coffee ? No Yes *If yes, how many cups per day?* _____

Do you use drugs (*marijuana, cocaine, etc*) ? No Yes *If yes, explain* _____

Do you want to be tested for AIDS ? No Yes

Have you ever worked with hazardous material ? No Yes *If yes, explain* _____

Are you in a physically abusive relationship ? 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

Are you using birth control ? No Yes *If so, what type?* _____