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

Yes ☐ No ☐

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

Past Medical History & Review of Systems

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

High Blood Pressure	Bronchitis	Change in Bowel Habits	Arthritis
Diabetes	Pneumonia	Unexpected Weight Gain	Low Back Problems
Cancer	Persistent Cough	Hemorrhoids	Skin Disease
Heart Disease	T.B.	Gall Bladder Disease	Blood Disorders
Chest Pain/Chest Tightness	Hay Fever	Colitis	Venereal Disease
Shortness of Breath	Abdominal Discomfort	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	

Other Symptoms or Illness:

Gynecological and Obstetric History

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

Pregnancies: Births: Miscarriages:

Prolonged or abnormal bleeding: No ☐ Yes ☐ (Describe)

Leakage of urine: No ☐ Yes ☐ (Describe)

Pelvic pain: No ☐ Yes ☐ (Describe)

Abnormal discharge No ☐ Yes ☐ (Describe)

History of abnormal Pap Smear: No ☐ Yes ☐ (Describe)

Type of treatment:

Please See Other Side!

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?	_____
Pneumovax Immunization?	No ☐	Yes☐	When?	_____
Flu Immunization?	No ☐	Yes☐	When?	_____
Tetanus Immunization?	No ☐	Yes☐	When?	_____
Other?	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 Member?	Approx. age when Diagnosed
Cancer (describe type)		
Hypertension (high blood pressure)		
Heart Disease		
Diabetes		
Stroke		
Mental Disease (anxiety, depression, etc.)		
Drug or Alcohol Addiction		
Glaucoma		
Bleeding Disease		
Other:		

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

Drug Name	Dose	Drug Name	Dose

Prevention

Do you wear a seatbelt?	No ☐	Yes☐	If no, why not? _____
Do you wear a bike helmet?	No ☐	Yes☐	
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 you have 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 materials?	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☐	