MEDICAL HISTORY Date:_____

Name:_____ Birthdate:_____

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
- ☐ ChestPain/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

_____
_____
_____
_____
_____
_____

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 you confidential medical record.

Please continue on the next page

MEDICAL HISTORY

Name:_____ Date:_____

Please List and Supply the Dates of:

Operations:

Type	Date	Type	Date

Hospitalizations other than for surgery:

Hospital	Reason	Date

Immunization History – Have you had:

Hepatitis B (Series of 3)? ☐No ☐Yes When?_____
Pneumovax Immunization? ☐No ☐Yes When?_____
Flu Immunization? ☐No ☐Yes When?_____
Meningitis Immunization? ☐No ☐Yes When?_____
Tetanus Immunization? ☐No ☐Yes When?_____
MMR Immunization? ☐No ☐Yes When?_____
PPD? ☐No ☐Yes When?_____
Hepatitis A(Series of 2)? ☐No ☐Yes When?_____

When was your last:

Pap Smear?_____ Breast Exam?_____ Stool check for blood?_____
Mammogram?_____ Cholesterol check?_____ Prostate check?_____

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

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Please continue on the next page

MEDICAL HISTORY

Name:_____ Date:_____

Prevention

Do you wear seat belts?	☐No ☐Yes	If no, why not?_____
Do you wear a bike helmet?	☐No ☐Yes	☐ N/A
Do you exercise regularly?	☐No ☐Yes	If yes, type, duration and number of times per week_____
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/tea?	☐No ☐Yes	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?	☐No ☐Yes	☐ N/A
Do you use drugs (marijuana, cocaine, 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	☐ N/A
Do you have a "living will"?	☐No ☐Yes	
Do you have a donor card?	☐No ☐Yes	

Method of birth control?_____

FAMILY HISTORY ↓ Names ↓	SEX		IF LIVING		IF NOT LIVING	
			AGE	HEALTH	AGE DIED	CAUSE
Father:						
Mother:						
↓ Brothers/Sisters ↓	(circle sex)					
	M	F				
	M	F				
	M	F				
	M	F				
	M	F				
	M	F				
Spouse:	M	F				
↓ Children ↓	(circle sex)					
	M	F				
	M	F				
	M	F				
	M	F				

What do you eat on an average day (breakfast, lunch, dinner & snacks)?

_____

_____

What do you do for exercise & how often per week?

_____

_____

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