



# 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:

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Change in bowel habits	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Unexplained weight gain/loss	<input type="checkbox"/> Low back problems
<input type="checkbox"/> Cancer	<input type="checkbox"/> Persistent cough	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Skin diseases
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> T.B.	<input type="checkbox"/> Gall Bladder disease	<input type="checkbox"/> Blood disorders
<input type="checkbox"/> Chest pain/chest tightness	<input type="checkbox"/> Hay fever	<input type="checkbox"/> Colitis	<input type="checkbox"/> Venereal diseases
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Abdominal discomfort	<input type="checkbox"/> Hepatitis or jaundice	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Swollen ankles	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Depression
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Nausea	<input type="checkbox"/> Head or neck radiation	<input type="checkbox"/> Anemia
<input type="checkbox"/> Lightheadedness	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Headache	<input type="checkbox"/> Alcohol abuse
<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Constipation	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Drug abuse
<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Kidney stones	<input type="checkbox"/> Gout
<input type="checkbox"/> Asthma	<input type="checkbox"/> Blood in stool	<input type="checkbox"/> Difficulty urinating	<input type="checkbox"/> Impotence or Erectile Dysfunction
	<input type="checkbox"/> Ulcers		<input type="checkbox"/> 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 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? \_\_\_\_\_ Colon Cancer Test? \_\_\_\_\_  
 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?  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 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.)  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"?  Yes  No  
 Do you have a donor card?  Yes  No  
 Method of birth control? \_\_\_\_\_

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