Medical History

PLEASE PRINT AND COMPLETE ALL INFORMATION Date: _____

Name: _____ Date of Birth: _____
Last First Middle

Occupation: _____ ☐Married ☐Single ☐Widowed ☐Divorced ☐Separated

If married, spouse's name: _____ Pharmacy Name and Phone: _____

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 or reaction

_____ _____ _____ _____

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

Drug Name	*Dose*	*Drug Name*	*Dose*	*Drug Name*	*Dose*

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:

- ☐ Alcohol abuse
- ☐ Abdominal discomfort
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood disorders
- ☐ Blood in stool
- ☐ Bronchitis
- ☐ Cancer
- ☐ Change in bowel habits
- ☐ Chest pain/chest tightness
- ☐ Colitis
- ☐ Constipation
- ☐ Depression
- ☐ Diarrhea
- ☐ Diabetes
- ☐ Difficulty urinating
- ☐ Drug abuse
- ☐ Emphysema
- ☐ Frequent urination
- ☐ Gall Bladder disease
- ☐ Gout
- ☐ Hay fever
- ☐ Head or neck radiation
- ☐ Headache
- ☐ Heart Disease
- ☐ Hemorrhoids
- ☐ Hepatitis or jaundice
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Impotence or Erectile Dysfunction
- ☐ Indigestion
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Lightheadedness
- ☐ Low back problems
- ☐ Nausea
- ☐ Palpitations
- ☐ Persistent cough
- ☐ Chicken Pox
- ☐ Pneumonia
- ☐ Rheumatic fever
- ☐ Shortness of breath
- ☐ Skin diseases
- ☐ Swollen ankles
- ☐ Tuberculosis
- ☐ Thyroid disease
- ☐ Ulcers
- ☐ Unexplained weight gain/loss
- ☐ Venereal disease
- ☐ Vomiting
- ☐ Other _____

_____

_____

Gynecologic and Obstetric History **Gynecologist: _____**

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 _____

This information is for use by the 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? _____ Colonoscopy? _____Bone Density Scan? _____

Mammogram? _____Dental Exam? _____Cholesterol check? _____ Eye exam? _____Prostate exam? _____

Family History Has any member of your immediate family (including parents, grandparents, and siblings) ever had the following?

Illness	*Which family member*	*Age when diagnosed*
Cancer (describe type)		
Hypertension		
Heart Disease		
Diabetes		
Strokes		
Mental disease (anxiety, depression, etc)		
Drug or alcohol addiction		
Glaucoma		
Bleeding disease		
Other		

Prevention Feel free to bring up issues you wish to discuss.

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? ☐ Yes ☐ No If yes, how many packs per day? _____

Do you drink alcoholic beverages? ☐ Yes ☐ No If yes, how much per week? _____

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

Do you drink tea? ☐ Yes ☐ No 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.) ☐ Yes ☐ No If yes, explain: _____

Have you ever engaged in any activity which has put you at risk of getting AIDS? ☐ Yes ☐ No If yes, explain: _____

Do you wish to be tested for AIDS? ☐ Yes ☐ No

Have you ever worked with chemicals, paints, asbestos, or other hazardous materials? ☐ Yes ☐ No

Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, bruised) by your partner? ☐ Yes ☐ No

Do you ever feel afraid of your partner? ☐ Yes ☐ No ☐ n/a

Do you have a "living will?" ☐ Yes ☐ No

Do you have a donor card? ☐ Yes ☐ No

Do you wear sunscreen? ☐ Yes ☐ No

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