

MEDICAL HISTORY

DATE: / /

Name _____ Age _____ Birth Date / /
 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 MEDICATION, 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. Bronchitis | 36. Change In Bowel Habits | 53. Arthritis |
| 2. Diabetes | 19. Pneumonia | 37. Unexplained Weight Gain/Loss | 54. Low Back Problems |
| 3. Cancer | 20. Persistent Cough | 38. Hemorrhoids | 55. Skin Diseases |
| 4. Heart Disease | 21. T.B. | 39. Gall Bladder Disease | 56. Blood Disorders |
| 5. Chest Pain/Chest Tightness | 22. Hay Fever | 40. Colitis | 57. Venereal Diseases |
| 6. Shortness Of Breath | 23. Abdominal Discomfort | 41. Hepatitis Or Jaundice | 58. Anxiety |
| 7. Swollen Ankles | 24. Indigestion | 42. Thyroid Disease | 59. Depression |
| 8. Palpitations | 25. Nausea | 43. Head Or Neck Radiation | 60. Anemia |
| 9. Light headedness | 26. Vomiting | 44. Headache | 61. Alcohol Abuse |
| 10. Frequent Urination | 27. Constipation | 45. Kidney Diseases | 62. Drug Abuse |
| 11. Rheumatic Fever | 28. Diarrhea | 46. Kidney Stones | 63. Gout |
| 12. Asthma | 29. Blood In Stool | 47. Difficulty Urinating | 64. Coughing Blood |
| 13. Breast Masses/Discharge | 30. Ulcers | 48. Painful Bowel Movement | 65. Change In Appetite |
| 14. Deafness | 31. Urinate At Night | 49. Blood in Urine | 66. Insomnia |
| 15. Muscle Pain | 32. Weakness | 50. Nasal Discharge | 67. Ringing of Ears |
| 16. Urinary Infections | 33. Urinary Incontinence | 51. Deformities | 68. Tingling/Numbness |
| 17. Neck Stiffness | 34. Post Nasal Drip | 52. Other: _____ | 69. Soreness Of Throat |
| | 35. Difficulty Swallowing | | 70. Other: _____ |

GYNECOLOGICAL 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 (type of treatment): _____

Next History Due: _____

PATIENT NAME: _____ **DATE:** / /

PLEASE LIST AND SUPPLY THE DATES OF:

Operations with dates:

Hospitalization other than for surgery with dates:

Immunization History —Have you had:

Pneumovax immunization? No Yes When? _____ Hepatitis B? No Yes When? _____
 Flu immunization? No Yes When? _____ Tetanus immunization? No Yes When? _____
When was your last: Dental exam? _____ Eye exam? _____ Pap smear? _____ Breast exam? _____
 Stool check for blood? _____ Mammogram? _____ Cholesterol check? _____ Prostate exam? _____

FAMILY HISTORY

Illness	Which Family Members?	Approx. 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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PREVENTION

- Do you wear seat belts? No Yes If no, why not? _____
- Do you wear a bike helmet? No Yes N/A
- Do you or have you ever smoked? No Yes If yes, # of packs per day/# of years _____
- Do you drink alcoholic beverages?
 - coffee? No Yes If yes, how much per week? _____
 - tea? No Yes If yes, how many cups per day? _____
- If there is a gun in your home, is it out of children's reach and unloaded? No Yes N/A
- Do you use illegal drugs? No Yes If yes, explain: _____
- Do you have risk factors for AIDS? No Yes If yes, explain: _____
- Do you wish to be tested for AIDS? No Yes
- Have you ever worked with hazardous chemicals, paints, asbestos? No Yes If yes, explain: _____
- Do you exercise regularly? No Yes
- 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 use a sun screen? No Yes
- Do you have a "living will"/advanced directive? No Yes Form given
- Do you have a donor card? No Yes
- Method of birth control? _____