

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:

- | | | | |
|--|---|---|--|
| <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"/> ChestPain/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 you confidential medical record.

Please continue on the next page

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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)?	<input type="checkbox"/> No <input type="checkbox"/> Yes	When? _____	Tetanus Immunization?	<input type="checkbox"/> No <input type="checkbox"/> Yes	When? _____
Pneumovax Immunization?	<input type="checkbox"/> No <input type="checkbox"/> Yes	When? _____	MMR Immunization?	<input type="checkbox"/> No <input type="checkbox"/> Yes	When? _____
Flu Immunization?	<input type="checkbox"/> No <input type="checkbox"/> Yes	When? _____	PPD?	<input type="checkbox"/> No <input type="checkbox"/> Yes	When? _____
Meningitis Immunization?	<input type="checkbox"/> No <input type="checkbox"/> Yes	When? _____	Hepatitis A(Series of 2)?	<input type="checkbox"/> No <input type="checkbox"/> Yes	When? _____
Gardasil	<input type="checkbox"/> No <input type="checkbox"/> Yes	When? _____	Polio Immunization?	<input type="checkbox"/> No <input type="checkbox"/> 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
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

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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