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

____
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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?__________	Tetanus Immunization?	☐No ☐Yes	When?__________
Pneumovax Immunization?	☐No ☐Yes	When?__________	MMR Immunization?	☐No ☐Yes	When?__________
Flu Immunization?	☐No ☐Yes	When?__________	PPD?	☐No ☐Yes	When?__________
Meningitis Immunization?	☐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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