

Medical History

Date: _____

Name _____

Age ___ Birthdate _____

Address _____

Sex _____

Occupation _____

Home Phone _____

Work Phone _____

Emergency Contact

Single _____ Married _____ Divorced _____ Widowed _____ Separated _____

If married, spouse's name _____

Children's name and ages _____

Allergies to medications, x ray, dyes, or other substances No ___ Yes _____

If yes, please list name of medicines 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 | 13. Bronchitis | 26. Change in bowel habits | 38. Arthritis |
| 2. Diabetes | 14. Pneumonia | 27. Weight changes | 39. Low back problem |
| 3. Cancer | 15. Persistent cough | 28. Hemorrhoids | 40. Skin diseases |
| 4. Heart Disease | 16. TB | 29. Gall Bladder | 41. Blood disorders |
| 5. Chest pain/tightness | 17. Hay fever | 30. Colitis | 42. Venereal diseases |
| 6. Shortness of breath | 18. Abdominal discomfort | 31. Hepatitis/Jaundice | 43. Anxiety |
| 7. Swollen Ankles | 19. Indigestion | 32. Thyroid disease | 44. Depression |
| 8. Palpitations | 20. Nausea | 33. Head/Neck radiation | 45. Anemia |
| 9. Lightheadedness | 21. Vomiting | 34. Headaches | 46. Alcohol abuse |
| 10. Frequent urination | 22. Constipation | 35. Kidney disease | 47. Drug abuse |
| 11. Rheumatic fever | 23. Diarrhea | 36. Kidney stones | 48. Gout |
| 12. Asthma | 24. Blood in stool | 37. Difficulty urinating | 49. _____ |
| | 25. Ulcer | | 50. _____ |

List present health problems and concerns: _____

Gynecologic and Obstetric History

Age at onset of periods: _____ Frequency _____ Length of period _____

Pregnancies _____ Births _____ Miscarriages _____

Prolonged or abnormal bleeding	No _____ Yes _____	Pls Describe _____
Leakage of urine	No _____ Yes _____	Pls Describe _____
Pelvic pain	No _____ Yes _____	Pls Describe _____
Abnormal discharge	No _____ Yes _____	Pls Describe _____
History of abnormal Pap smear	No _____ Yes _____	Pls Describe _____

Please list and supply the dates of:

Operations _____

Hospitalization other than surgery _____

Immunization history - have you had:

Pneumovax	No _____ Yes _____	When? _____
Hepatitis B	No _____ Yes _____	When? _____
Flu	No _____ Yes _____	When? _____
Tetanus	No _____ Yes _____	When? _____
Other	No _____ Yes _____	When? _____

Last Chest xray _____ Last Pap _____ Last Mammogram _____

Last Hemocult _____ Last sigmoidoscopy or colonoscopy _____

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	_____	_____
Hypertension	_____	_____
Heart Disease	_____	_____
Diabetes	_____	_____
Strokes	_____	_____

Father Alive Age _____ Health problems _____

Dead Age at death _____ Cause _____

Mother Alive Age _____ Health problems _____

Dead Age at death _____ Cause _____

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

Drug name _____ Dose _____

Drug name _____ Dose _____

Drug name _____ Dose _____

Drug name _____ Dose _____

Drug name _____ Dose _____

Drug name _____ Dose _____

Drug name _____ Dose _____

Prevention

Do you wear seatbelts? No ___ Yes ___ If no, why not? _____

Do you wear a bike helmet? No ___ Yes ___ N/A ___

Do you smoke now? ___ Have you ever? ___ How long? ___ How many per day? ___ Quit date _____

Weight now _____ 1 year ago _____ Maximum _____ When _____

Do you consume coffee/tea? ___ How many cups per day? ___ Alcohol/ How much? _____

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 material? No ___ Yes ___ If yes, explain _____

Are you or have you ever been in a abusive relationship? No ___ Yes ___ If yes, explain _____

Are you afraid of your partner? No ___ Yes ___ If yes, explain _____

Do you have a "living will? No ___ Yes _____

Do you have a donor card? No ___ Yes _____

Method of birth control? _____