



MEDICAL HISTORY

DATE

NAME	AGE	DATE OF BIRTH	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female
ADDRESS	HOME PHONE		
	CELL PHONE		
EMERGENCY CONTACT	EMERGENCY CONTACT PHONE		
OCCUPATION	PREVIOUS PCP		
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated			
IF MARRIED, SPOUSE'S NAME			
CHILDREN'S NAMES AND AGES			

Allergies to Medications, X Ray Dyes, or Other Substances Yes No
 (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"/> Low back problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Unexplained weight gain/loss | <input type="checkbox"/> Skin diseases |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Persistent cough | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Blood disorders |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> T.B. | <input type="checkbox"/> Gall Bladder disease | <input type="checkbox"/> Venereal diseases |
| <input type="checkbox"/> Chest pain/chest tightness | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Colitis | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Abdominal discomfort | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Swollen Ankles | <input type="checkbox"/> Nausea | <input type="checkbox"/> Asthma | <input type="checkbox"/> Alcohol abuse |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Anemia | <input type="checkbox"/> Headache | <input type="checkbox"/> Head or neck radiation |
| <input type="checkbox"/> Hepatitis or jaundice | <input type="checkbox"/> Constipation | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Drug abuse |
| <input type="checkbox"/> Lightheadedness | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Impotence or Erectile Dysfunction |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Other |
| <input type="checkbox"/> Difficulty urinating | <input type="checkbox"/> Indigestion | | |

Gynecologic and Obstetric History

AGE AT ONSET OF PERIODS	FREQUENCY	LENGTH OF PERIOD
PREGNANCIES	BIRTHS	MISCARRIAGES

- Prolonged or abnormal bleeding Yes No Please describe _____
- Leakage of urine Yes No Please describe _____
- Pelvic pain Yes No Please describe _____
- Abnormal discharge Yes No Please describe _____
- History of abnormal Pap smear Yes No Please describe _____

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Please List and Supply the Dates of:

OPERATIONS
HOSPITALIZATIONS OTHER THAN FOR SURGERY

Immunization History – Have you had:

Hepatitis B immunization? Yes No When _____

Tetanus immunization? Yes No When _____

Pneumovax immunization? Yes No When _____

Flu shot? Yes No When _____

Other? _____ Yes No When _____

When was your last:

PAP SMEAR?	BREAST EXAM?	COLON CANCER TEST?
MAMMOGRAM?	CHOLESTEROL CHECK?	PROSTATE EXAM?

Family History – Has any member of your family ever had the following?

Illness	Which family members? Please indicate Maternal (M) or Paternal (P)	Age Diagnosed
Cancer (describe type)		
Hypertension (high blood pressure)		
Heart Disease		
Diabetes		
Strokes		
Mental disease (anxiety, depression, etc.)		
Drug or alcohol addiction		
Glaucoma		
High cholesterol		
Other _____		

Medications (Prescription, Over-the-Counter, Vitamins, Herbs, etc.) (Please list drug name and dose)

Prevention

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 # 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 If yes, explain: _____

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

Method of birth control? _____

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