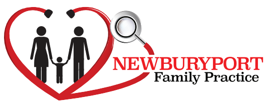

MEDICAL HISTORY

DATE

NAME	AGE	DATE OF BIRTH	GENDER ☐ Male ☐ Female
ADDRESS	HOME PHONE		
	CELL PHONE		
EMERGENCY CONTACT	EMERGENCY CONTACT PHONE		
OCCUPATION	PREVIOUS PCP		

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ 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:

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Chest pain/chest tightness
- ☐ Shortness of Breath
- ☐ Swollen Ankles
- ☐ Palpitations
- ☐ Hepatitis or jaundice
- ☐ Lightheadedness
- ☐ Frequent urination
- ☐ Rheumatic fever
- ☐ Difficulty urinating
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Persistent cough
- ☐ T.B.
- ☐ Hay fever
- ☐ Abdominal discomfort
- ☐ Nausea
- ☐ Anemia
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in stool
- ☐ Vomiting
- ☐ Indigestion
- ☐ Change in bowel habits
- ☐ Unexplained weight gain/loss
- ☐ Hemorrhoids
- ☐ Gall Bladder disease
- ☐ Colitis
- ☐ Thyroid Disease
- ☐ Asthma
- ☐ Headache
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Ulcers
- ☐ Arthritis
- ☐ Low back problems
- ☐ Skin diseases
- ☐ Blood disorders
- ☐ Venereal diseases
- ☐ Anxiety
- ☐ Depression
- ☐ Alcohol abuse
- ☐ Head or neck radiation
- ☐ Drug abuse
- ☐ Gout
- ☐ Impotence or Erectile Dysfunction
- ☐ Other

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 ______

This information is for use by your physician as part of your confidential medical record.

Continue to next page ▶

MEDICAL HISTORY

NAME	DATE

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 your 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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