Medical History

Date: ______________________

To be completed by persons 18 years and older

Name:	Age:	Birthdate:
Address:	Sex: □ Male □ Female	
	Home phone:	
	Work phone:	
Occupation:	Emergency contact:	
	Phone:	
□ Single □ Married	□ Divorced □ Widowed	□ Separated
If married, spouse's name:		
Children's names and ages:		

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 of if you have had any problems with or are presently experiencing any of the following:

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

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 your confidential medical record.

Please continue on the 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? □ No □ Yes When?
Other? □ No □ Yes When?
Pneumovax immunization? □ No □ Yes When?
Flu immunization? □ No □ Yes When?
Tetanus immunization? □ No □ Yes When?

When was your last:		
Pap smear?	Breast exam?	Stool check for blood?
Mammogram?	Cholesterol check?	Prostate exam?

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 disease		
Other:		

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

Drug Name	Dose	Drug Name	Dose	Drug Name	Dose

Prevention

Question			
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 number or 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:

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

Please continue on the next page

MEDICAL HISTORY **Name: ________________________________** **Date: ____________________**

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?			

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