

Medical History

Date: / /

Name _____	Age _____	Birthdate / /
Address _____	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
_____	Home phone _____	
_____	Work phone _____	
Occupation _____	Emergency contact _____	
	Phone _____	
<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 No Yes

(If yes, please list name of medicine 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. Unexplained weight gain/loss	39. Low back problems
3. Cancer	15. Persistent cough	28. Hemorrhoids	40. Skin diseases
4. Heart disease	16. T.B.	29. Gall bladder disease	41. Blood disorders
5. Chest pain/chest tightness	17. Hay fever	30. Colitis	42. Venereal diseases
6. Shortness of breath	18. Abdominal discomfort	31. Hepatitis or jaundice	43. Anxiety
7. Swollen ankles	19. Indigestion	32. Thyroid disease	44. Depression
8. Palpitations	20. Nausea	33. Head or neck radiation	45. Anemia
9. L	21. Vomiting	34. Headache	46. Alcohol abuse
10. Frequent urination	22. Constipation	35. Kidney diseases	47. Drug abuse
11. Rheumatic fever	23. Diarrhea	36. Kidney stones	48. Gout
12. Asthma	24. Blood in stool	37. Difficulty urinating	49. _____
	25. Ulcers		50. _____

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 (Type of treatment): _____

Please List and Supply the Dates of:

Operations: _____

Hospitalizations other than for surgery: _____

Immunization history—have you had: Pneumovax immunization? No Yes When? _____

Hepatitis B? No Yes When? _____ Flu immunization? No Yes When? _____

Other? 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?	Approx. 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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Prevention

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? No Yes If yes, how many cups per day? _____

Do you drink tea? No Yes If yes, how many cups per day? _____

Have you ever worked with chemicals, paints, asbestos, or other hazardous material? No Yes If yes, explain: _____

Do you have a "living will"? No Yes

Do you have a donor card? No Yes