

Medical History

Date: / /

Name: _____ Age: _____ Birthdate: _____
 Address: _____ Sex: *Circle one:* Male Female
 _____ Home Phone: _____
 _____ Work Phone: _____
 _____ Status: ___ Single ___ Married ___ Divorced ___ Widowed
 _____ Separated
 Occupation: _____
 If married, Spouse's Name: _____
 Children, Names & 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 experiencing any of the following:

- | | | |
|-------------------------------|----------------------------------|--------------------------|
| 1. High blood pressure | 19. Indigestion | 37. Difficulty urinating |
| 2. Diabetes | 20. Nausea | 38. Arthritis |
| 3. Cancer | 21. Vomiting | 39. Low back problems |
| 4. Heart disease | 22. Constipation | 40. Skin diseases |
| 5. Chest pain/chest tightness | 23. Diarrhea | 41. Blood disorders |
| 6. Shortness of breath | 24. Blood in stool | 42. Venereal diseases |
| 7. Swollen ankles | 25. Ulcers | 43. Anxiety |
| 8. Palpitations | 26. Change in bowel habits | 44. Depression |
| 9. Lightheadedness | 27. Unexplained weight gain/loss | 45. Anemia |
| 10. Frequent urination | 28. Hemorrhoids | 46. Alcohol abuse |
| 11. Rheumatic fever | 29. Gall bladder disease | 47. Drug abuse |
| 12. Asthma | 30. Colitis | 48. Gout |
| 13. Bronchitis | 31. Hepatitis or jaundice | 49. _____ |
| 14. Pneumonia | 32. Thyroid disease | 50. _____ |
| 15. Persistent cough | 33. Head or neck radiation | _____ |
| 16. T.B | 34. Headache | _____ |
| 17. Hay fever | 36. Kidney stones | _____ |

Gynecologic & Obstetric History

Age at onset of periods: _____ Frequency: _____ Length of period: _____
 Pregnancies: _____ Births: _____ Miscarriages: _____
 Prolonged or abnormal bleeding: ___ No ___ Yes (Describe): _____
 Leakage of urine: ___ No ___ Yes (Describe): _____
 Pelvic pain: ___ No ___ Yes (Describe): _____
 Abnormal discharge: ___ No ___ Yes (Describe) _____

Please List & 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, & siblings) ever had the following?

<i>ILLNESS</i>	<i>WHICH FAMILY MEMBERS?</i>	<i>APPROX. AGE WHEN DIAGNOSED</i>
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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Pharmacy: Name: _____ *Number:* _____
Address (if available): _____

Prevention: Please circle the answers that apply to you.

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 & # of times/week? _____
 Do you smoke? Yes No If yes, how many packs/day? _____
 Do you drink alcohol? Yes No If yes, how much/week? _____
 Do you drink coffee? Yes No If yes, how many cups/day? _____
 Do you drink tea? Yes No If yes, how many cups/day? _____

If there is a gun in your home, do you keep it unloaded & out of children's reach? Yes No N/A

Do you use illegal drugs? 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 material? Yes No If yes, explain: _____

Are you in a physically abusive relationship? 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? _____