Medical History *Date: / /*

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

_____

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?

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

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? _____