Medical History

Date:___________________________

Name _______________________________________

Age___ Birthdate _______________

Address _____________________________________

Sex ______

Occupation _________________________________

Home Phone ___________________

Work Phone ____________________

Emergency Contact

Single_____ Married _____ Divorced _____ Widowed _____ Separated _______

If married, spouse's name ____

Children's name and ages ____

Allergies to medications, x ray, dyes, or other substances No ___ Yes _____
If yes, please list name of medicines and type of reaction: ______________________________________

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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
2. Diabetes
3. Cancer
4. Heart Disease
5. Chest pain/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. TB
17. Hay fever
18. Abdominal discomfort
19. Indigestion
20. Nausea
21. Vomiting
22. Constipation
23.Diarrhea
24. Blood in stool
25. Ulcer
26. Change in bowel habits
27. Weight changes
28. Hemorrhoids
29. Gall Bladder
30. Colitis
31. Hepatitis/Jaundice
32. Thyroid disease
33. Head/Neck radiation
34. Headaches
35. Kidney disease
36. Kidney stones
37. Difficulty urinating
38. Arthritis
39. Low back problem
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. ______________

List present health problems and concerns: ____

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Gynecologic and Obstetric History

Age at onset of periods: ___________ Frequency ___________ Length of period _______________

Pregnancies _________ Births___________ Miscarriages __________________

Prolonged or abnormal bleeding No ____ Yes _____ Pls Describe ______________________________
Leakage of urine No ____ Yes_____ Pls Describe ______________________________
Pelvic pain No ____ Yes_____ Pls Describe ______________________________
Abnormal discharge No ____ Yes _____ Pls Describe ______________________________
History of abnormal Pap smear No ____ Yes_____ Pls Describe ______________________________

Please list and supply the dates of:

Operations ________________________________ ____
________________________________ ____

Hospitalization other than surgery _____________________________ ______________________________

_____________________________ ______________________________

Immunization history - have you had: Pneumovax No _____ Yes ____ When? _______________________
Hepatitis B No _____ Yes ____ When? _______________________
Flu No _____ Yes ____ When? _______________________
Tetanus No _____ Yes ____ When? _______________________
Other No _____ Yes ____ When? _______________________

Last Chest xray _____________________ Last Pap_________________ Last Mammogram _____________

Last Hemoccult ____________________ Last sigmoidoscopy or colonoscopy _________________________

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	____________________________	_______________________
Hypertension	____________________________	_______________________
Heart Disease	____________________________	_______________________
Diabetes	____________________________	_______________________
Strokes	____________________________	_______________________

Father Alive Age_________ Health problems____

Dead Age at death _______________ Cause____

Mother Alive Age_________ Health problems ____

Dead Age at death_______________ Cause ____

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

Drug name____ Dose ____________________________________

Drug name____ Dose ____________________________________

Drug name____ Dose ____________________________________

Drug name____ Dose ____________________________________

Drug name____ Dose ____________________________________

Drug name____ Dose ____________________________________

Drug name____ Dose ____________________________________

Prevention

Do you wear seatbelts? No ____ Yes ____ If no, why not? ____

Do you wear a bike helmet? No ____ Yes ____ N/A ____

Do you smoke now? _____ Have you ever? ______ How long? _____ How many per day?_____ Quit date ______

Weight now ____________ 1 year ago _____________ Maximum ________________ When _________________

Do you consume coffee/tea? _____ How many cups per day? _______ Alcohol/ How much? __________________

Do you use drugs? (marijuana, cocaine, crack, etc.) No___ Yes___ If yes,explain ____________________________

Have you ever engaged in any activity which has put you at risk of getting AIDS? No___ Yes ___ If yes, explain

____

Do you wish to be tested for AIDS? No ____ Yes _____

Have you ever worked with chemicals, paints, asbestos, or other hazardous material? No___ Yes ___ If yes, explain

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Are you or have you ever been in a abusive relationship? No___ Yes ___ If yes, explain

____

Are you afraid of your partner? No___ Yes ___ If yes, explain

____

Do you have a “living will? No ____ Yes _____

Do you have a donor card? No ____ Yes _____

Method of birth control? ____