Medical History **Date: / /**

Name _____ Age _____ Birthday ____/____/____ Sex ____

Address _____

Home phone _____ Work phone _____ Cell phone _____

Occupation _____ Emergency contact_____ Phone _____

Single _____ Married _____ Divorced _____ Widowed _____ Separated _____

If married, spouse's name _____ Children's names and ages _____

Allergies to Medications, X-rays, or Other Substances _____

Past Medical History and 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/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
18. Abdominal discomfort
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
35. Kidney diseases
36. Kidney stones
37. Difficulty urinating
38. Arthritis
39. Low back pain
40. Skin disease
41. Blood disorders
42. Venereal disease
43. Anxiety
44. Depression
45. Anemia
46. Alcohol abuse
47. Drug abuse
48. Gout
49. _____
50. _____

Gynecologic and Obstetric History

Age at onset of periods: ____ Frequency: _____Length of period: _____

Pregnancies: _____ Births: _____Miscarriages: _____ Method of birth control? ____

Prolonged or abnormal bleeding: ____ Leakage of urine: _____ Pelvic pain: _____

Abnormal discharge: _____ History of abnormal Pap smear: _____ Type of treatment: _____

Please List and Supply the Dates of:

Operations: _____

Hospitalizations other than for surgery: _____

Immunization history

Hepatitis B ____ Tetanus immunization _____ Flu immunization _____ Pneumovax immunization _____

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,…)	_____	_____
Drug or alcohol addiction	_____	_____
Glaucoma	_____	_____
Bleeding diseases	_____	_____

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

_____

_____

Prevention:

Do you wear seat belt? _____ Do you wear a bike helmet? _____
Do you smoke? (how much)_____ Do you drink tea? (how much) _____
Do you drink alcoholic beverages? (how much) _____ Do you drink coffee? (how much) _____
If there is a gun in your home, do you keep it unloaded and out of children's reach? _____
Do you use drugs? (marijuana, cocaine, crack, etc.) _____
Have you ever engaged in any activity which has put you at risk of getting AIDS? _____
Do you wish to be tested for AIDS? ____
Have you ever worked with chemicals, paints, asbestos, or other hazardous material? _____
Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, bruised) by your partner? ____
Do you ever feel afraid of your partner? _____
Do you have a "living will"? _____ Do you have a donor card? ____

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