Medical History *Date: / /* *C06*

Demographics

Name ______ *Birthdate* __/__/__ *Age:* ____ *Sex:* ☐ *M* ☐ *F*
Address ______ *Home phone* ______ *Mobile* ______
______ *Work phone* ______
Occupation ______ *Emergency contact* ______ *Phone* ______

☐ *Single* ☐ *Married* ☐ *Divorced* ☐ *Widowed* ☐ *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 medication, x-ray dyes or other substances 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
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 diseases
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 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 (Please describe):* ______
Pap Smear ☐ *No* ☐ *Yes* *Date:* ______
Breast Exam ☐ *No* ☐ *Yes* *Date:* ______
Mammogram ☐ *No* ☐ *Yes* *Date:* ______

Operations and Hospitalizations: Please List and Supply the Dates of:

Operations: ______ ______
______ ______

Hospitalizations other than for surgery: ______ ______
______ ______

Immunization history—have you had:

Pneumovax immunization: ☐**No** ☐**Yes Date:** ______ **Flu immunization** ☐**No** ☐**Yes Date:** ______
Hepatitis B: ☐**No** ☐**Yes Date:** ______ **Tetanus immunization** ☐**No** ☐**Yes Date:** ______
Other: ______ ☐**No** ☐**Yes Date:** ______ **Other:** ______ ☐**No** ☐**Yes Date:** ______

When was your last:

Stool Check for blood: _____________ **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

Question	Answer
Do you wear seatbelts?	No Yes If no, why not?___________________
Do you wear a bike helmet?	No Yes N/A
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?_____
If there is a gun in your home?	No Yes
Is it out of children's reach and unloaded?	No Yes
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_____________
Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, bruised) by your partner?	No Yes
Do you ever feel afraid of your partner?	No Yes
Do you have a "living will"?	No Yes
Do you have a donor card?	No Yes

Method of birth control?____

Physician Review____**Date**________________