

MEDICAL HISTORY**DATE:** / /

Name: _____	Age: _____	Birthdate: _____/_____/_____
Address: _____ _____	Sex: () Female () Male	
	Home Phone: _____	
	Work Phone: _____	
Occupation: _____	Emergency Contact Name: _____	
	Emergency Contact Phone number: _____	
() Single () Married () Divorced () Widowed () Separated		
If married, spouse's name: _____		
Children's Names and ages: _____		

Allergies to Medications, X-Ray Dyes, or Other Substances: (If yes, please list name of medicine and type of reaction) :	() NO	() YES
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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	13. Bronchitis	26. Change in Bowel Habits	38. Arthritis
2. Diabetes	14. Pneumonia	27. Unexplained Weight Loss / Gain	39. Low back Problems
3. Cancer	15. Persistent Cough	28. Hemorrhoids	40. Skin Diseases
4. Heart Disease	16. T.B.	29. Gall bladder Disease	41. Blood Disorders
5. Chest Pain / Tightness	17. Hay fever	30. Colitis	42. Venereal Diseases
6. Shortness of Breath	18. Abdominal Discomfort	31. Hepatitis or Jaundice	43. Anxiety
7. Swollen Ankles	19. Indigestion	32. Thyroid Disease	44. Depression
8. Palpitations	20. Nausea	33. Head or Neck radiation	45. Anemia
9. Lightheadedness	21. Vomiting	34. Headaches	46. Alcohol Abuse
10. Frequent Urination	22. Constipation	35. Kidney Disease	47. Drug Abuse
11. Rheumatic Fever	23. Diarrhea	36. Kidney Stones	48. Gout
12. Asthma	24. Blood in stools	37. Difficulty urinating	49. Ulcers
Other conditions or information: _____			

Gynecologic and Obstetric History:			
Age at Onset of periods: _____	Frequency: _____	Length of Periods: _____	
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	Type of Treatment: _____	

MEDICAL HISTORY

Please list and Supply the Dates:

Operations: _____

Hospitalizations other than for surgery: _____

Immunization history – have you had: Pneumovax immunization: () NO () YES When? _____

Flu Vaccination () NO () YES When? _____ Hepatitis B () NO () YES When? _____

Tetanus Booster () NO () YES When? _____ OTHER : _____

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 (Parents, Grandparents, and Siblings) ever had the following:

ILLNESS	WHICH FAMILY MEMBERS:	APPROX AGE DIAGNOSED?
CANCER (DESCRIBE TYPE)	_____	_____
HYPERTENSION:	_____	_____
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:

DO YOU WEAR SEAT BELTS ? () NO () YES IF NO WHY? _____

DO YOU WEAR A BIKE HELMET? () NO () YES () NA

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 OR TEA ? () NO () YES If YES, how many cups per week? _____

If there is a GUN in your home, do you safely store it, unloaded? () YES () NO () NA

Do You Use DRUGS(marijuana,cocaine,crack,etc)? () NO () YES If YES, explain _____

Have You Ever Engaged in Activity that would put you at high risk for AIDS? () NO () YES-explain _____

Do You Wish To Be Tested for AIDS? () NO () YES

Have You Ever Worked with Hazardous Chemicals/Materials? () 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? _____

Are You In A Relationship In Which You Have Been Physically Injured By Your Partner? () NO () YES
(e.g. slapped, kicked, punched,etc.)