MEDICAL HISTORY

Name:_____
Address: _____
_____
_____
Occupation:_____
Social Sec #:_____
Single | Divorced | Widowed | Separated
If Married, Spouse's Name_____

Age:_____ Date of Birth: _____
Sex: Male | Female
Home Phone:_____
Work Phone:_____
Emergency Contact:_____
Emergency Contact Phone:_____
Who referred you to our office?:_____
Children Names & ages_____

_____

Allergies to Medications, X-ray Dyes, or Other Substances (If yes, please list name of medicine and type of reaction)

_____

_____

Social History

Do you presently smoke? YES NO
Do you use any illicit drugs? YES NO
Have you ever been a significant smoker? YES NO
How much alcohol do you drink weekly? _____

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/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 disease
36. Kidney stones
37. Difficulty urinating
38. Arthritis
39. Low back problems
40. Skin disease
41. Venereal
42. Anxiety
43. Blood disorders
44. Depression
45. Anemia
46. Alcohol abuse
47. Drug abuse
48. Gout

Gynecologic and Obstetric History

Age at Onset of Periods:_____ Frequency:_____ Length of Period:_____
Pregnancies:_____ Birth:_____ 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:_____

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

Drug Name	Dose	Drug Name	Dose

Please list and supply the dates of:

Operations: _____

_____

_____

Hospitalizations other than for surgery: _____

_____

_____

Immunization History: **(Have you had any of the following & if so, when?)**

Pneumovax Immunization	_____YES	____NO	Hepatitis A	_____YES	____NO
Influenza Immunization	_____YES	____NO	Hepatitis B	_____YES	____NO
Tetanus Immunization	_____YES	____NO	Varicella	_____YES	____NO
Tuberculosis Test	_____YES	____NO	MMR	_____YES	____NO

Other: _____

Routine Exams: **(Have you had any of the following & if so, when?)**

Mammogram	_____YES	____NO	Breast Exam	_____YES	____NO
DexaScan	_____YES	____NO	PAP Smear	_____YES	____NO
Cholesterol Check	_____YES	____NO	Colonoscopy	_____YES	____NO
Prostate Exam	_____YES	____NO	EKG	_____YES	____NO
Stool Check for Blood	_____YES	____NO			

Family History:

Has any member of your family (including parents, grandparents, children, and siblings) ever had the following?

Illness	*Which family member(s)?*	*Approx. age when discovered?*
Cancer (describe type)		
Hypertension		
Heart Disease		
Diabetes		
Strokes		
Mental Disease (anxiety, depression, etc.)		
Drug or Alcohol Addiction		
Glaucoma		
Colon Polyps		

Are your parents still alive? ____YES ____NO if so, age(s)? _____

Prevention:

Do you wear seatbelts? ____YES ____NO If no, why not? _____

Do you wear a bike helmet? ____YES ____NO ____N/A

Do you drink coffee? ____YES ____NO If yes, how many cups per day? _____

Do you drink tea? ____YES ____NO If yes, how many cups per day? _____

Is there a gun in your home? ____YES ____NO ____N/A

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 get tested for AIDS? ____YES ____NO

Have you ever worked with chemicals, paints, asbestos, or hazardous materials? 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? ____YES ____NO If yes, explain _____

*****This information is used by your physician as part of your confidential medical record.*****