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	*13. Bronchitis*	*26. Change in bowel habits*	*38. Arthritis*
2. Diabetes	*14. Pneumonia*	*27. Unexplained weight gain/loss*	*39. Low back problems*
3. Cancer	*15. Persistent cough*		*40. Skin diseases*
4. Heart disease	*16. T.B.*	*28. Hemorrhoids*	*41. Blood disorders*
5. Chest pain/chest tightness	*17. Hay fever*	*29. Gall bladder disease*	*42. Venereal diseases*
	18. Abdominal discomfort	*30. Colitis*	*43. Anxiety*
6. Shortness of breath	*19. Indigestion*	*31. Hepatitis or jaundice*	*44. Depression*
7. Swollen ankles	*20. Nausea*	*32. Thyroid disease*	*45. Anemia*
8. Palpitations	*21. Vomiting*	*33. Head or neck radiation*	*46. Alcohol abuse*
9. Lightheadedness	*22. Constipation*	*34. Headache*	*47. Drug abuse*
10. Frequent urination	*23. Diarrhea*	*35. Kidney diseases*	*48. Gout*
11. Rheumatic fever	*24. Blood in stool*	*36. Kidney diseases*	*49.* _____
12. Asthma	*25. Ulcers*	*37. Difficulty urinating*	*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

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**_____