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: ( ) **NO** ( ) **YES**
(If yes, please list name of medicine and type of reaction) :

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

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.Veneral 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.)