

MEDICAL HISTORY

Date _____

Name _____ Age _____ Birthdate _____
Address _____ Sex Male Female
Home Phone _____
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 medicine and type of reaction)

Past Medical History and Review of Systems
Please check off if **you** have had any problems with or are presently experiencing any of the following:

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Change in bowel habits	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Unexplained weight gain/loss	<input type="checkbox"/> Low back problems
<input type="checkbox"/> Cancer	<input type="checkbox"/> Persistent cough	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Skin diseases
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> T.B.	<input type="checkbox"/> Gall Bladder disease	<input type="checkbox"/> Blood disorders
<input type="checkbox"/> Chest pain/chest tightness	<input type="checkbox"/> Hay fever	<input type="checkbox"/> Colitis	<input type="checkbox"/> Venereal diseases
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Abdominal discomfort	<input type="checkbox"/> Hepatitis or jaundice	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Swollen ankles	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Depression
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Nausea	<input type="checkbox"/> Head or neck radiation	<input type="checkbox"/> Anemia
<input type="checkbox"/> Lightheadedness	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Headache	<input type="checkbox"/> Alcohol abuse
<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Constipation	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Drug abuse
<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Kidney stones	<input type="checkbox"/> Gout
<input type="checkbox"/> Asthma	<input type="checkbox"/> Blood in stool	<input type="checkbox"/> Difficulty urinating	<input type="checkbox"/> Impotence or Erectile Dysfunction
	<input type="checkbox"/> Ulcers		<input type="checkbox"/> Other

This information is for use by your physician as part of your confidential medical record.

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Name _____ Date _____

Please List and Supply the Dates of:

Operations _____

Hospitalizations other than for surgery _____

Immunization history—have you had:
 Hepatitis B? No Yes When? _____
 Other? No Yes When? _____
 Pneumovax immunization? No Yes When? _____
 Flu immunization? No Yes When? _____
 Tetanus immunization? No Yes When? _____

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 (including parents, grandparents, and siblings) ever had the following?

Illness	Which family members?	Age when diagnosed
Cancer (describe type)	_____	_____
Hypertensions (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	Drug Name	Dose
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Prevention

Do you wear seat belts? Yes No If no, why not? _____

Do you wear a bike helmet? Yes No N/A

Do you exercise regularly? Yes No If yes, type, duration and number of times per week? _____

Do you smoke? Yes No If yes, how many packs per day? _____

Do you drink alcoholic beverages? Yes No If yes, how much per week? _____

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? _____

If there is a gun in your home, do you keep it unloaded and out of children's reach? Yes No N/A

Do you use drugs? (marijuana, cocaine, crack, etc.) Yes No If yes, explain: _____

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 be tested for AIDS? Yes No

Have you ever worked with chemicals, paints, asbestos, or other hazardous materials? Yes No If yes, explain: _____

Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, bruised) by your partner? 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? _____

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