Medical History Form

NAME_____ **DOB**___/___/___ **TODAY'S DATE**_____

MEDICAL HISTORY

What medical Conditions do you have? Select all that apply, or write in if not listed:

Diabetes___ High Blood Pressure___ Thyroid Disorder___ Heart Disease____ High Cholesterol____
Arthritis ____ Cancer____ Kidney Disease____ Glaucoma ___ Asthma____ Allergies____
Migraine Headache ____ Anemia____ Bronchitis/Emphysema____ Obesity____ Acid Reflux _____

Other: 1-_____ 2-_____ 3-_____

Women Only: Age of first menstrual cycle_____ Date of last period _____
Do you have a history of irregular menstrual cycles?_____ (Y / N)
Are you currently on birth control?_____ If yes, what type / name?_____
Number of pregnancies? _____ # of live births? _____ # of Miscarriages?_____
Have you had an abnormal Pap result? _____ If yes, when? (year)_____
How often do you self-breast exam? (circle one) Never Rarely Weekly Monthly

SURGICAL & HOSPITALIZATION HISTORY

List all of surgeries or hospitalizations (with cause) you have had in the past 10 years?

_____ _____

_____ _____

_____ _____

SOCIAL

How much do you smoke?_____ How many years?_____
How much alcohol (including beer) do you drink in week?_____
Have you used or currently use recreational drugs? YES___ NO___ If yes how long_____
Please list people you currently live with:_____
Are you: ____Single ____Married ____Divorced ____Other?_____

Is your health (check one) ____Excellent ____Good ____Poor

Have you ever been a victim of domestic violence? Including: physical, psychological, emotional, economic, and sexual abuse? _____

Do you have a gun in your house? ____YES ____NO

What is your occupation? Please include any unusual or potentially dangerous exposures you might have at work._____

Please list types of exercise you participate in_____

How often do you exercise per week?_____ How long do you exercise during this time?_____

SEXUAL

Were you under age 18 when you had your first sexual contact? ____YES ____NO

How many sexual partners have you had in the past? Male_____ Female_____

Have you ever had a sexually transmitted disease? ____YES ____NO If yes, please list type(s)_____

FAMILY HISTORY

Please list if any family members have had the following illness. Please list their relation to you.

Family Member	Current Age	Living? (Y /N)	Medical Conditions	Cause of Death (if deceased)	Age at Death
Mother					
Father					
Sister					
Sister					
Brother					
Brother					

Continue on back of page if more

HEALTH MAINTENANCE

Please list the year of your last screening test below: (please indicate if there were any abnormal results)

PAP smear: _____ Mammogram: _____ Colonoscopy: _____ Eye Exam: _____

Cholesterol Test: _____ Prostate Exam: _____ Dental Exam: _____ Blood Work: _____

Immunizations/vaccine- Please list the year of your last:

Tetanus Shot: _____ Flu Shot: _____ Pnemovax (Pneumonia shot): _____ Hepatitis A_____
Hepatitis B: _____ Chicken Pox: _____ TB Skin Test:_____

Medications currently taking (with dosage):

Medication	Dosage	The time(s) of the day you take it

Vitamins or supplements currently taking:

_____ _____ _____

Allergic reactions to medicine or foods: Please list the TYPE OF REACTION.

Medication / Food Allergy	Reaction
_____	_____
_____	_____
_____	_____

Please check any **CURRENT** symptoms with a **C** and any **PAST** symptoms with a **P**

GENERAL

_____Fever

_____Weight Loss

_____Weight Gain

EYES

____Vision Changes

____Double Vision

____Eye Pain/Irritation

____Yellow Eyes (jaundice)

EARS, NOSE, THROAT

____Hearing Loss

____Sinus Pain

____Nose Bleeds

____Seasonal Allergies

____Lumps in mouth

____Jaw pain

MUSCULOSKELETAL

____Joint Pain

____Muscle weakness

____Back Pain

____Trouble Walking

____Cramping

SKIN

____Rash

____ New skin growths

____Change in Moles

____Warts

____Skin Cancer

____Itchy Skin

____Dry Skin

____Bleeding

____Oily Skin

____ Brittle nails

MEN

____Difficulty urinating

____Trouble with erections

____ Change in urination

WOMEN

____PMS

____ Cramping

____ Abnormal vaginal bleeding

____Irregular menstrual cycle

____Lump in breast

____Abnormal discharge from nipples

____Uterine fibroids

____Excessive menstrual bleeding

-------- Hot flashes

_____ Mood changes

_____ "Heavy" sensation in abdomen

_____ Vaginal irritation

Ears, Nose, Throat

____Teeth or gum pain

____Ringing in Ears

____Soars in Mouth

____Difficulty swallowing

____Painful Swallowing

____Postnasal Drip

____Sneezing

CARDIOVASCULAR

____Chest Pain

____Palpitations

____Swelling of the Legs

____Irregular heartbeat

____Abnormal EKG

____High Cholesterol

____Shortness of Breath

RESPIRATORY

____Wheezing

____Coughing

____Coughing up Blood

____Pneumonia

____Asthma

_____ Shortness of Breath

NEUROLOGIC

____Seizures

____Numbness

____Stroke

____Twitching

____Headaches/Migraines

____Dizziness

BEHAVIORAL

____Trouble Sleeping

____Trouble Concentrating

____Depression

____Feeling "blue" or "down"

____Marital problems

____Anxiety

____Mood swings

____Panic Attacks

GASTROINTESTINAL

____Stomach Pain

____Ulcer

____Constipation

____Diarrhea

____Hemorrhoids

____Blood in Stool

ENDOCRINE

____Hair Loss

____Feeling or Cold

____Excessive Thirst

____Frequent Thirst

____Frequent Urination

____Excessive Hair Growth

HEMATOLOGIC

____Unusual Bleeding

____Unusual Bruising

____Anemia

____Enlarge Lymph Nodes

GENITOURINARY

____Kidney Stones

____Blood in Urine

____Urinary Tract Infection