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Medical History *Date:* / /

Name: _____ Sex: ☐ M ☐ F / Age:___ Birthdate:_____

Address: _____ Home Phone:_____

_____ Work Phone:_____

_____ Emergency Contact:_____

Occupation:_____ 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 & 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. Swollen ankles
6. Palpitations
7. Lightheadedness
8. Rheumatic fever
9. Asthma
10. Bronchitis
11. Pneumonia
12. T.B.
13. Hay fever
14. Abdominal discomfort
15. Indigestion
16. Blood in stool
17. Ulcers
18. Change in bowel habits
19. Unexplained weight gain/loss
20. Hemorrhoids
21. Gall bladder disease
22. Collitis
23. Hepatitis or jaundice
24. Thyroid disease
25. Head or neck radiation
26. Kidney disease
27. Kidney stones
28. Difficulty urinating
29. Arthritis
30. Lower back problems
31. Skin diseases
32. Blood disorders
33. Venereal diseases
34. Anemia
35. Alcohol abuse
36. Drug abuse
37. Gout
38. Other_____
_____

Immunization History – *Have you had*:

Hepatitis B: ☐ No ☐ Yes When?_____ Tetanus: ☐ No ☐ Yes When?_____

Pneumovax Immunization: ☐ No ☐ Yes When?_____ Gardasil: ☐ No ☐ Yes When?_____

Flu Immunization: ☐ No ☐ Yes When?_____ Other: ☐ No ☐ Yes When?_____

When Was Your Last:

Pap smear:_____ Breast exam:_____ Stool check for blood:_____

Mammogram:_____ Prostate Exam:_____ Cholesterol Check:_____

Patient Name *(print)*:_____DOB:_____

Gynecologic & Obstetric History

1. Age at onset of periods: _____ Frequency: _____ Length of period: _____
2. How many pregnancies?: _____ How many births?: _____ Any miscarriages?: _____
3. 1st day of last menstrual cycle . . . . Date:_____
4. Prolonged or abnormal bleeding: ☐ No ☐ Yes (*please describe*): _____
5. Leakage of urine: ☐ No ☐ Yes (*please describe*): _____
6. Pelvic pain: ☐ No ☐ Yes (*please describe*): _____
7. Abnormal discharge: ☐ No ☐ Yes (*please describe*): _____
8. History of abnormal pap smear: ☐ No ☐ Yes (*please describe*):

Please List and Supply the Dates for the Following:

Operations: _____ _____
_____ _____

Other Hospitalizations: _____ _____
_____ _____

Family History – *Has any family member (parents, grandparents, siblings) ever had the following?*

	Type & Relationship	When diagnosed
Cancer:		
Hypertension:		
Heart Disease:		
Diabetes:		
Strokes:		
Mental Illness (*depression,etc):*		
Drug / Alcohol Addiction:		

Do you smoke ? ☐ No ☐ Yes *If yes, how many packs per day?*_____
Do you drink alcohol ? ☐ No ☐ Yes *If yes, how much per day?*_____
Do you drink coffee ? ☐ No ☐ Yes *If yes, how many cups per day?*_____
Do you use drugs *(marijuana, cocaine, etc)* ? ☐ No ☐ Yes *If yes, explain*_____
Do you want to be tested for AIDS ? ☐ No ☐ Yes
Have you ever worked with hazardous material ? ☐ No ☐ Yes *If yes, explain*_____
Are you in a physically abusive relationship ? ☐ 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
Are you using birth control ? ☐ No ☐ Yes *If so, what type?*_____