



## Patient Medical History

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Name you prefer to be called: \_\_\_\_\_

Primary Care MD: \_\_\_\_\_ Referring MD: \_\_\_\_\_

Drug Allergies: \_\_\_\_\_ No Medication Allergies Eggs Latex Iodine

Current Contraception: \_\_\_\_\_ Date of Last annual Exam: \_\_\_\_\_

1st day of last menstrual period: \_\_\_\_\_

What concerns do you want to discuss at today's appointment? \_\_\_\_\_

What symptoms do you want to talk to the provider about? \_\_\_\_\_

Other physician/provider visits since last time here? (for same condition)  Yes  No

If yes, (who/where): \_\_\_\_\_

Do you have specific requests for:

New Medication: \_\_\_\_\_

Refills: \_\_\_\_\_

Vaccinations: \_\_\_\_\_

Referrals: \_\_\_\_\_

Tests: \_\_\_\_\_

Completion of forms: \_\_\_\_\_

School or work release: \_\_\_\_\_

Other: \_\_\_\_\_

### Surgical History

Date	Surgery	MD/Hospital	Complications
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### Obstetrical History (Including Miscarriages and Terminations)

Have you had any miscarriages?  No  Yes, When: \_\_\_\_\_

Have you had any terminations?  No  Yes, When: \_\_\_\_\_

Date	Child's Sex/Name	Birth Weight	Labor Length	Vag/Cesarean	MD/Hosp	Complications
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## Family History

Mother Living Y N Diseases: \_\_\_\_\_  None  
 If Yes, Age \_\_\_\_\_ If No, Cause of Death and age \_\_\_\_\_

Father Living Y N Diseases: \_\_\_\_\_  None  
 If Yes, Age \_\_\_\_\_ If No, Cause of Death and age \_\_\_\_\_

Maternal Grandmother Living Y N Diseases: \_\_\_\_\_  None  
 If Yes, Age \_\_\_\_\_ If No, Cause of Death and age \_\_\_\_\_

Paternal Grandmother Living Y N Diseases: \_\_\_\_\_  None  
 If Yes, Age \_\_\_\_\_ If No, Cause of Death and age \_\_\_\_\_

Maternal Grandfather Living Y N Diseases: \_\_\_\_\_  None  
 If Yes, Age \_\_\_\_\_ If No, Cause of Death and age \_\_\_\_\_

Paternal Grandfather Living Y N Diseases: \_\_\_\_\_  None  
 If Yes, Age \_\_\_\_\_ If No, Cause of Death and age \_\_\_\_\_

Brother/Sister (circle one) Living Y N Diseases: \_\_\_\_\_  None  
 If Yes, Age \_\_\_\_\_ If No, Cause of Death and age \_\_\_\_\_

Brother/Sister (circle one) Living Y N Diseases: \_\_\_\_\_  None  
 If Yes, Age \_\_\_\_\_ If No, Cause of Death and age \_\_\_\_\_

Brother/Sister (circle one) Living Y N Diseases: \_\_\_\_\_  None  
 If Yes, Age \_\_\_\_\_ If No, Cause of Death and age \_\_\_\_\_

Brother/Sister (circle one) Living Y N Diseases: \_\_\_\_\_  None  
 If Yes, Age \_\_\_\_\_ If No, Cause of Death and age \_\_\_\_\_

## Past Illnesses

Have you experienced any of the following:

AIDS/HIV	Asthma	Cancer	Stroke	Diabetes	Heart Disease	Ulcers
Thyroid problems	Phlebitis	Seizures	Arthritis	Diverticulosis	Kidney infection	Gonorrhea
Chlamydia	Herpes	Genital warts				

## Personal/Family History

Have you or any close members of your family including grandparents, aunts and/or uncles had any of the following medical conditions?

	Patient	Family	Relationship	Age Diagnosed
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Ovarian Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Endometrial Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Colon Polyps	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Ulcerative Colitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Heart Disease/Angina	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Elevated Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Broken Hip/Spine	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Blood Clots/Thrombosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Problems w/Anesthesia	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

## Menstrual History

Age at onset: \_\_\_\_\_ Frequency \_\_\_\_\_ Days of flow \_\_\_\_\_ Heavy flow  
 Menopause: Age \_\_\_\_\_

## Social History

Marital Status     Single             Married             Divorced             Widowed             Partnered             Separated  
 Number of children living? \_\_\_\_\_  
 Special diet?     No             Weight Loss     Low Fat             Vegan             Diabetic             Vegetarian  
 Exercise?         None             Routine of \_\_\_\_\_  
 Do you do monthly breast exams?     Yes             No  
 Calcium intake?     0-1 servings daily             2-3 servings daily             Supplements  
 Are you employed?     Yes             No Where \_\_\_\_\_ Position \_\_\_\_\_  
 Do you smoke?     No             Yes            Frequency/Quantity \_\_\_\_\_  
 Do you drink alcohol?     0             Infrequent     1-4             5-8             10-12             13+ average drinks per week  
 Do you use street drugs?     No     Yes     Marijuana     Other Frequency/Quantity \_\_\_\_\_  
 Is anyone physically or emotionally hurting you?     No             Yes,            Who? \_\_\_\_\_  
 Are you sexually active?             Yes             No  
 Do you have multiple sexual partners?     No             Yes,    # in last year? \_\_\_\_\_

## Vaccinations

Have you been immunized against the following? Include dates if possible.

Measles \_\_\_\_\_ Mumps \_\_\_\_\_ Rubella \_\_\_\_\_ Tetanus \_\_\_\_\_  
 Chickenpox \_\_\_\_\_ Polio \_\_\_\_\_ Hepatitis B \_\_\_\_\_ Hepatitis A \_\_\_\_\_  
 Have you had a TB test?     No             Yes,            Year \_\_\_\_\_ Result \_\_\_\_\_

## Please check if you are now or recently experiencing any of the following:

Constitutional:     Anorexia/Bulemia     Weight loss     Weight gain     Fatigue     Sweating     Fever  
 Eyes:             Vision loss             Double vision             Spots  
 Ear/Nose/Throat:     Ringing in ear     Earache             Sore throat             Bleeding gums             Congestion  
 Cardiac:             Chest pain             Palpitations             Swelling (location \_\_\_\_\_ )  
 Respiratory:         Wheezing             Cough             Shortness of breath  
 GI:                 Constipation         Diarrhea             Bloating             Black or bloody stools  
 GU: Urine:         Frequency             Urgency             Burning             Incontinence             Pain  
     Periods:         Cramps             Irregular             Heavy             Spotting     PMS  
     Vagina:         Dryness             Itching             Discharge     Painful     Intercourse  
     Menopause:     Hot flashes         Night sweats         Other \_\_\_\_\_  
 Muscle:             Joint pain             Muscle cramps         Weakness  
 Skin:               Rash             Dryness             Lesions             Acne             Moles  
 Breast:             Lump             Discharge             Pain             Skin changes  
 Neuro:             Headaches         Dizziness             Tremors             Weakness             Seizures  
 Psych:             Depression         Anxiety             Insomnia             Memory loss             Moodiness  
 Endo:               Excess thirst     Hair loss             Excess hair     Cold/heat intolerance     Excess urination  
 Lymph:             Bruising             Nosebleeds             Swollen glands

Please list current ***PRESCRIBED*** medications you are taking along with the strength and dose.

Medication	Strength	Dose

Please list current ***OVER THE COUNTER*** medications you are taking along with the strength and dose.

Medication	Strength	Dose

***SIGNATURE:*** \_\_\_\_\_

***DOB:*** \_\_\_\_\_

***DATE:*** \_\_\_\_\_