Medical History Form

Your answers on this form will help us understand your medical concerns and conditions better. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details.

Name_________________________________ Date of Birth____________ Today's date__________

1. Personal Medical History

Please indicate if you have had any of the following problems currently or in the past.

Anemia	☐ Yes	☐ No	Kidney disease/stones	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Liver disease/Hepatitis	☐ Yes	☐ No
Asthma/Emphysema	☐ Yes	☐ No	Lung disease/pneumonia	☐ Yes	☐ No
Bladder infections	☐ Yes	☐ No	Pancreatitis	☐ Yes	☐ No
Chronic diarrhea	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Diverticulosis	☐ Yes	☐ No	Skin disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Sleep apnea	☐ Yes	☐ No
If yes, what age?______			Stroke	☐ Yes	☐ No
Emotional problems	☐ Yes	☐ No	Venereal disease/Syphilis	☐ Yes	☐ No
Epilepsy or Seizures	☐ Yes	☐ No	Gonorrhea/Chlamydia	☐ Yes	☐ No
Gallstones	☐ Yes	☐ No	Thyroid disease/Goiter	☐ Yes	☐ No
Gout	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Tumors/Cancer	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No	Ulcers (stomach or intestinal)	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Acid Reflux (Heartburn)	☐ Yes	☐ No

If yes to any of the above, please explain____

____

____

When was your last Tetanus shot given? ______________

2. Family History ☐ **Adopted**, family history unknown.

Has anyone in your family (including grandparents, parents, brothers, sisters, or children) had any of the following conditions?

			Family Relationship:	**Living/Deceased:**
Alcoholism	☐ Yes	☐ No	____________________	__________________
Anemia	☐ Yes	☐ No	____________________	__________________
Arthritis	☐ Yes	☐ No	____________________	__________________
Bowel/Colon Cancer	☐ Yes	☐ No	____________________	__________________
Breast Cancer	☐ Yes	☐ No	____________________	__________________
Depression	☐ Yes	☐ No	____________________	__________________
Diabetes	☐ Yes	☐ No	____________________	__________________
Heart Disease/Angina	☐ Yes	☐ No	____________________	__________________
Hepatitis	☐ Yes	☐ No	____________________	__________________
High Blood Pressure	☐ Yes	☐ No	____________________	__________________
High Cholesterol	☐ Yes	☐ No	____________________	__________________
Kidney Disease	☐ Yes	☐ No	____________________	__________________
Strokes	☐ Yes	☐ No	____________________	__________________
Thyroid Disorder	☐ Yes	☐ No	____________________	__________________
Tuberculosis	☐ Yes	☐ No	____________________	__________________
Other_________________	☐ Yes	☐ No	____________________	__________________

3. Personal Habits

Tobacco Use

Cigarettes: ☐ Never ☐ Quit-Date______ ☐ Current Smoker-Packs per day___ # of years___

Other tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Are you interested in quitting? ☐ Yes ☐ No

Alcohol Use

Do you drink alcohol? ☐ No ☐ Yes, average # of drinks per week_____

If no, have you in the past? ☐ Yes ☐ No

Drug Use

Do you use any recreational drugs, such as marijuana, cocaine, stimulants, narcotics, diet pills?
☐ Yes ☐ No

Have you ever used needles? ☐ Yes ☐ No.

Sexuality

Are you sexually active? ☐ Yes ☐ No ☐ Not currently

If sexually active, do you practice safe sex? ☐ Yes ☐ No

Birth control method________________

Have you ever had any sexually transmitted diseases (STD's)? ☐ Yes ☐ No

If yes, please include____

Exercise

Do you exercise regularly? ☐ Yes ☐ No

If yes, what type of exercises?____

Emotions

In the past year, have you had 2 weeks or more during which you felt sad, blue, or depressed; or when you lost interest or pleasure in things that you usually enjoyed? ☐ Yes ☐ No

4. Medications

Please list all your current medications, including medications/supplements not needing a prescription:

Medication	Dose and Directions

5. Allergies

Please list any allergies or reactions to medications:

Medication	Reaction or Side Effect

6. Operations

Have you had any operations? If yes, list:

Type of operation / Reason for operation	Hospital / Facility	Date of operation
______________________________	__________________	______________
______________________________	__________________	______________
______________________________	__________________	______________
______________________________	__________________	______________
______________________________	__________________	______________
______________________________	__________________	______________
______________________________	__________________	______________

7. For Women Only

Total # of pregnancies_____ # of deliveries_____ # of miscarriages_____ # of abortions_____

Age at start of menstrual period ________

Date most recent menstruation began ________

Usual length of menstrual period ________ days

Date of last Pap smear ________

Have you ever had an abnormal Pap smear? ☐ Yes ☐ No

If yes, give date and describe____

Have you stopped having menstrual periods? ☐ Yes ☐ No If yes, when_________________

Do you have regular problems with:

Irregular, painful, or heavy menstrual periods ☐ Yes ☐ No

Bleeding between periods or after menopause ☐ Yes ☐ No

Vaginal discharge, pain or itching ☐ Yes ☐ No

Hot flashes ☐ Yes ☐ No

Pain or lumps in breasts ☐ Yes ☐ No

Please return to:

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