MEDICAL HISTORY

NAME____________________________ AGE______ DATE OF BIRTH ____________

PREVIOUS SURGERY (Include dates and procedures)

____
____
____
____

PREVIOUS HOSPITALIZATIONS (Include dates and reason)

____
____
____
____

MEDICATION ALLERGIES

____

CURRENT MEDICATIONS

____
____
____
____
____
____
____

PLEASE LIST ALL PHYSICIANS SEEN IN THE PAST YEAR (Include reason for visit and phone number____

____
____
____
____

FAMILY HISTORY (List medical and psychiatric problems)

	AGE	DECEASED?	PROBLEM
FATHER			
MOTHER			
SISTER(S)			
BROTHER(S)			
CHILDREN			
GRANDPARENTS			

DO YOU EXERCISE REGULARLY? (frequency, type)

____

DO YOU FOLLOW A SPECIAL DIET? (If yes, what type?)

____

HOW MUCH CAFFEINE DO YOU CONSUME DAILY ? (Number and type of beverages) ____
WHAT IS YOUR OCCUPATION? ____
HAVE YOU BEEN EXPOSED TO HEALTH RISKS AT WORK? ________________
IS THERE A HISTORY OF HIGH RISK SEXUAL BEHAVIOR? ________________

PLEASE INDICATE IF YOU HAVE HAD ANY OF THESE PROBLEMS, AND WHEN

Ringing in the ears ____
Nosebleeds ____
Sinus problems ____
Hay fever or allergies ____
Difficulty swallowing ____
Thyroid disorder ____
Asthma ____
Shortness of breath ____
Persistent cough ____
TB or positive TB skin test ____
Abnormal chest X-ray ____
Chest pain ____
Irregular heart beat ____
High blood pressure ____
Heart attack ____
Peptic ulcer ____
Persistent indigestion ____
Frequent constipation ____
Frequent diarrhea ____
Hemorrhoids or blood in the stool ____
Hepatitis or liver abnormality ____
Urinary infections ____
Urinary incontinence ____
Kidney stones ____
HIV Infection ____
Gall stones or gall bladder disease ____
Arthritis or joint pains ____
Back problems ____
Herpes infections ____
Convulsion or seizure ____
Dizziness ____
Insomnia ____
Weight loss or gain recently ____
Fatigue or loss of energy ____
Loss of appetite ____
Loss of sex drive ____
History of blood clots ____
Easy bruising ____

History of blood transfusions ____
Hernia ____

FEMALE PATIENTS
Last menstrual period ____
Number of pregnancies ____
Number of live births ____
Miscarriages____

Method of current birth control ____
Date of last Pap test ____
History of abnormal Pap test ____
Date of last mammogram ____
History of abnormal mammogram ____
Pain with intercourse ____
Vaginal infection or discharge ____
Venereal warts or infection ____
Are you currently pregnant? ____

MALE PATIENTS

Prostate problems ____
Venereal warts or disease ____
Erectile dysfunction ____
Enlarged testicle or cyst ____

IMMUNIZATION HISTORY

Diphtheria-tetanus booster in the last 10 years ____________________________
Hepatitis B ____
MMR ____
Polio ____
Influenza ____
Pneumovax ____
Chicken pox/varicella ____

ALL PATIENTS

PLEASE LIST ALL SUPPLEMENTS AND VITAMINS TAKEN __________________
____
____
____
____
____
____

PLEASE GIVE HISTORY OF TOBACCO USE INCLUDING AGE STARTED, WHAT FORM OF TOBACCO USED, AND WHETHER STILL USING ____________________

____

____

PLEASE LIST ANY OTHER HEALTH INFORMATION NOT INDICATED ABOVE

____

____

____

____

____

Signature____ Date____________________

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