Medical History

Date: ___________________________

Name __________________________________ Age_________________ Birth date ___________

Sex: ☐ Male ☐ Female

Occupation ______________________________ Primary Care Physician __________________________

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Why Are You Here Today (present illness)?:____

Medical/Surgical History:

Do you have any of the following medical conditions?

□ Diabetes □ Heart Disease □ High Blood Pressure □ Kidney Disease □ Liver Disease □ Asthma

□ Emphysema □ Other:____

Operations and Dates: _____________ __________________________ ______________________

_______________________ __________________________ ______________________

Hospitalization other than for surgery __________________________ ______________________

Do you need to take antibiotics pre-operatively? ☐ Yes ☐ No

Have you had a rectal exam / colonoscopy? ☐ Yes ☐ No Date _________________

Have you ever had a blood transfusion? ☐ Yes ☐ No Date _________________

Medications (Prescription, Over-the-Counter, Vitamins, Herbs, Supplements, ect.)

Drug Name	Dose	Drug Name	Dose	Drug Name	Dose
__________________	-________	__________________	-________	__________________	-________
__________________	-________	__________________	-________	__________________	-________
__________________	-________	__________________	-________	__________________	-________

Allergies to Medications, Foods, Latex or Other Substances ☐ No ☐ Yes

(If yes, please list name of medicine and type of reaction)

____-_______________________________________

____-_______________________________________

____-_______________________________________

____-_______________________________________

Social History

Do you exercise regularly? □ Yes □ No If yes, type, duration ____________________

Do you smoke? □ Yes □ No If yes, how many packs per day? __________

If you did smoke, but quit when? __________

Do you chew tobacco? □ Yes □ No If yes, how much?____________________

Do you drink alcoholic beverages? □ Yes □ No If yes, how much per week? ______________

Do you drink coffee? □ Yes □ No If yes, how many cups per day? ___________

Do you use drugs (Marijuana, cocaine) □ Yes □ No If yes, explain ______________________

Are you alone at home? □ Yes □ No If yes, do you have relatives nearby? _______

Emergency Contact:____

Please continue on the next page

Gynecologic and Obstetric History

Pregnancies ________ Full term Births ________ Miscarriages ___________ Abortions _________

Breast Exam ☐ No ☐ Yes Date ____

Mammogram ☐ No ☐ Yes Date ____

Pelvic Exam ☐ No ☐ Yes Date ____

Pap Smear ☐ No ☐ Yes Date ____

Menstrual Cycle:

Date of Last period: _____________ Age at onset of periods _______________ Length of period _____

Any menopausal symptoms? ☐ **No** ☐ **Yes** ____

Medical History and Review of Systems

Please check off if **you** have had any problems with or are presently experiencing any of the following:

- ☐ Headache
- ☐ Migraine
- ☐ Numbness
- ☐ Dizziness
- ☐ Stroke
- ☐ Anxiety
- ☐ Depression
- ☐ Kidney disease
- ☐ Bladder infection
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Pain on urination
- ☐ Chemotherapy
- ☐ Hearing Aid
- ☐ Chest pain/pressure
- ☐ Angina
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Valve Problems
- ☐ Rheumatic Fever
- ☐ Blood clot to Lungs
- ☐ Congestive Failure
- ☐ Heart Murmur
- ☐ Swelling feet/ankles
- ☐ Circulation problems
- ☐ Cancer
- ☐ Venereal disease
- ☐ Arthritis
- ☐ Asthma
- ☐ Shortness of Breath
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Chronic Cough
- ☐ Bronchitis
- ☐ Hay Fever
- ☐ Coughing up blood
- ☐ Wheezing
- ☐ Diabetes
- ☐ Anemia
- ☐ Anesthesia Reaction
- ☐ Other: ___________________________
- ☐ Nausea/vomiting
- ☐ Ulcers
- ☐ Hiatal Hernia
- ☐ Bloody Stool
- ☐ Jaundice
- ☐ Liver Problems
- ☐ Hepatitis
- ☐ Vomiting Blood
- ☐ Diarrhea
- ☐ Constipation
- ☐ Alcoholism
- ☐ Bleeding Tendency
- ☐ Dentures

Family History has any member of your family (including parents grandparents and siblings ever had any of the following?

Illness	Which Family Member
Cancer (describe type)	______________________
Hypertension (high blood pressure)	______________________
Heart Disease	______________________
Diabetes	______________________
Kidney Disease	______________________
Stroke	______________________
Thyroid Disease	______________________
Anesthesia Reaction	______________________
Bleeding Tendency	______________________

To the best of my knowledge, the above information is true and correct.

Patients Signature: ______________________________________ Date: _________________________

HT__________ WT__________ BPL__________ R_____P_____ R_________