Medical History

Each of us has a health history that is different from anyone else's. That is why it will be useful if you spend a few minutes filling out this form. We can review it when we discuss the reasons for your visit.

Name____________________ Today's Date__________

Marital Status__________ Date of Birth__________ Occupation__________

Your History (Past and Present)

Yes	No		Yes	No		Yes	No	
____	____	High Blood Pressure	____	____	Thyroid Disorder	____	____	Cancer
____	____	Heart Disease	____	____	Diabetes	____	____	Glaucoma
____	____	High Cholesterol	____	____	Prostate Disorder	____	____	Stroke
____	____	Asthma/Emphysema	____	____	Rheumatic Fever	____	____	Stomach Ulcers
____	____	Seizure Disorder	____	____	Anemia	____	____	Tuberculosis
____	____	Chicken Pox	____	____	Hepatitis	____	____	Depression

Have you ever been hospitalized for medical reasons or surgery? (If yes, please give dates and nature of illness). __________

Do you have any other medical problems not mentioned above? __________

Are you currently seeing any other doctors? (If yes, please give physicians' name and condition being treated): __________

Medications

List all medications (including birth control, vitamins, and over-the-counter medications): __________

Allergies

Medication Allergies? __________

Other Allergies? __________

Vaccination

When was your last tetanus shot? __________

Have you ever received vaccination for:			
pneumonia	Y	N	If yes when ________
Hepatitis B	Y	N	________
Hepatitis A	Y	N	________
Pediatric Pneumonia	Y	N	If yes when ________

Social History

Do you use tobacco? Y N How much?______ How long?______ Did you quit?______

Do you drink alcohol? Y N How much?______ How long?______ Did you quit?______

Are you under any unusual stress? Y N Explain __________

Are you sexually active? Y N Method of contraception __________

Do you exercise regularly? Y N Do you wear seatbelts? Y N Bike Helmet? Y N

At home, do you have smoke detectors? Y N Carbon Monoxide detector Y N Gun(s)? Y N

Have you signed: A living will? Y N Durable power of attorney for health care? Y N

An organ donor card? Y N

(over)

C300

Family History (Immediate family only — indicate which relative)

Yes	No		Mother	Father	Sister(s)	Brother(s)	Other (grandparents, aunts, uncles, cousins)
____	____	High Blood Pressure	____	____	____	____	____
____	____	Diabetes	____	____	____	____	____
____	____	Heart Disease	____	____	____	____	____
____	____	Stroke	____	____	____	____	____
____	____	High Cholesterol	____	____	____	____	____
____	____	Cancer ____________ Type	____	____	____	____	____
____	____	Glaucoma	____	____	____	____	____
Other: ____________			____	____	____	____	____

If any parents or siblings are deceased, please give ages and cause of death: ____________

____

System Review (Please check YES if you have had any of the following problems on a regular basis):

Yes	No	
____	____	Frequent or severe headaches
____	____	Blurred vision
____	____	Wear glasses or contacts
____	____	Ringing in ears
____	____	Hearing loss
____	____	Hay fever
____	____	Nose bleeds
____	____	Difficulty swallowing
____	____	Chest pain or pressure
____	____	Heartburn or indigestion
____	____	Nausea and/or vomiting
____	____	Diarrhea
____	____	Constipation
____	____	Change in bowel habits
____	____	Blood in stool
____	____	Hemorrhoids
____	____	Change in weight
____	____	Heart murmur

Yes	No	
____	____	Shortness of breath
____	____	Pneumonia/Bronchitis
____	____	Cough
____	____	Night Sweats
____	____	Urinary frequency
____	____	Burning in urination
____	____	Kidney stones
____	____	Blood, sugar or protein in urine
____	____	Arthritis Location____________
____	____	Back pain
____	____	Thirsty or hungry all the time
____	____	Tingling feelings in extremities
____	____	Unconsciousness for any reason
____	____	Dizziness
____	____	Nervousness
____	____	Bruising
____	____	Skin rashs and/or disorders
____	____	Colon Cancer Screening?

Women only:

- ______ Date of last menstrual period?
- Y N Are your periods regular?
- Y N Postmenopausal bleeding?
- ______ Number of children?
- Y N Any miscarriages or abortions?
- Y N Have you ever had an abnormal PAP smear?
- ______ When was your last PAP smear?
- ______ When was your last mammogram?
- Y N Do you perform breast self-exams?

Men Only:

- Y N Prostate Nodules?
- Y N Weak urinary stream or dribbling?
- Y N Do you wake up at night to urinate?
- Y N Do you perform testicular self-exams?
- Y N Have you had prostate cancer screening?
- Y N Have you had problems with impotence?

Gynecologist ____________________