Medical History

(Please print)

Patient Name: | Today's Date:

Allergies (to Medications, X-ray Dyes, etc.) ▫ Yes ▫ No If Yes, please list name of medicine and type of reactions:

Medical History (please check if you have had problems with or are experiencing any of the following)

▫ High Blood Pressure	▫ Palpitations	▫ Abdominal Pain	▫ Ulcers	▫ Thyroid Disease
▫ Diabetes	▫ Lightheadedness	▫ Indigestion	▫ Change in bowel habits	▫ Head or neck radiation
▫ Cancer	▫ Asthma	▫ Nausea	▫ Unexplained weight gain/loss	▫ Headache
▫ Heart Disease	▫ Bronchitis	▫ Vomiting	▫ Hemorrhoids	▫ Kidney diseases
▫ Chest pain/tightness	▫ Pneumonia	▫ Constipation	▫ Gall Bladder Disease	▫ Kidney Stones
▫ Shortness of Breath	▫ T.B.	▫ Diarrhea	▫ Colitis	▫ Difficulty Urinating
▫ Swollen Ankles	▫ Hay Fever	▫ Blood in stool	▫ Hepatitis or jaundice	▫ Alcohol Abuse
▫ Low back problems	▫ Venereal Disease	▫ Anemia	▫ Anxiety	▫ Drug Abuse
▫ Skin Diseases	▫ Blood Disorders	▫ Arthritis	▫ Depression	▫ Other:

Gynecological and Obstetric History

Age at onset of menstrual cycle: _____
Average length: _____ Frequency: _____

of: Pregnancies: _____
Births: _____ Miscarriages: _____

Date of last Pap smear: __________
History of abnormal Pap smear: ▫Y ▫N
Date of last breast exam: __________
Date of last mammogram: __________

Past Surgical and Hospitalization History (Describe past surgeries and/or hospitalizations, please indicate the dates)

Immunization History (please check if you have had any of the following and indicate the date)

▫ Hepatitis B	▫ Pneumovax	▫ Flu	▫ Tetanus

Screenings please list the date of your last:

Prostate Exam:	Cholesterol Check:	Stool Check for blood:

Family History (please check when appropriate)

Illness	Mother	Father	Sibling	Children	Grandparent
Cancer (describe)					
High Blood Pressure					
Heart Disease					
Diabetes					
Strokes					
Mental Disease (anxiety, depression, etc)					
Drug or alcohol addiction					
Glaucoma					
Bleeding Diseases					
Other:					

Medications (prescription, over the counter, vitamins, herbs, etc.)

Name	Dose	Name	Dose

Social History

Do you smoke?	▫Yes ▫No	If yes, how many packs per day?
Do you drink alcoholic beverages?	▫Yes ▫No	If yes, how much per week?