Medical History

Date _____/_____/_____

Name _____ Age _____ DOB _____/_____/_____ Sex ❑ M ❑ F

Address _____ Home Phone _____

City, State Zip _____ Cell Phone _____

Occupation _____ Emergency Contact _____

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

If married, spouse's name _____

Children's names & ages _____

Allergies to Medications, X-Ray Dyes, or Other Substances

❑ Yes ❑ No

If yes, please list name of medicine and type of reaction:

_____

_____

_____

_____

Past Medical History & Review of Systems

Please circle if you have had problems with or are presently complaining of any of the following:

1. High blood pressure
2. Diabetes
3. Cancer
4. Heart disease
5. Chest pain / chest tightness
6. Shortness of breath
7. Swollen ankles
8. Palpitations
9. Lightheadedness
10. Frequent urination
11. Rheumatic fever
12. Asthma
13. Bronchitis
14. Pneumonia
15. Persistent cough
16. T.B.
17. Hay fever
18. Abdominal discomfort
19. Indigestion
20. Nausea
21. Vomiting
22. Constipation
23. Diarrhea
24. Blood in stool
25. Ulcers
26. Change in bowel habits
27. Unexplained weight gain / loss
28. Hemorrhoids
29. Gall bladder disease
30. Colitis
31. Hepatitis or jaundice
32. Thyroid disease
33. Head or neck radiation
34. Headache
35. Kidney diseases
36. Kidney stones
37. Difficulty urinating
38. Arthritis
39. Low back problems
40. Skin diseases
41. Blood disorders
42. Venereal diseases
43. Anxiety
44. Depression
45. Anemia
46. Alcohol abuse
47. Drug abuse
48. Gout
49. _____
50. _____

_____

_____

_____

_____

Gynecologic and Obstetric History

Age at onset of periods: _____ Frequency: _____ Length of period: _____

Pregnancies: _____ Births: _____ Miscarriages: _____

Prolonged or abnormal bleeding: ❑ No ❑ Yes (Please describe) _____

Leakage of urine: ❑ No ❑ Yes (Please describe) _____

Pelvic pain: ❑ No ❑ Yes (Please describe) _____

Abnormal discharge: ❑ No ❑ Yes (Please describe) _____

History of abnormal Pap smear: ❑ No ❑ Yes (Please describe) _____