MEDICAL HISTORY

PATIENT INFORMATION:

FULL NAME:	SEX:	AGE:	DOB:
Height:	Weight:		

Reason for Visit (chief complaint including date of onset):

DO YOU OR HAVE YOU EVER HAD:

Yes	No		Yes	No		Yes	No	
☐	☐	HIGH BLOOD PRESSURE	☐	☐	BLEEDING TENDENCIES	☐	☐	SYNCOPE/FAINTING
☐	☐	STROKE	☐	☐	ANEMIA	☐	☐	CHRONIC SWOLLEN GLANDS
☐	☐	HEART ATTACK	☐	☐	AIDS/HIV	☐	☐	VISUAL IMPAIRMENT/ DRY EYE
☐	☐	IRREGULAR HEART BEATS	☐	☐	TRANSFUSIONS	☐	☐	CATARACTS
☐	☐	THROMBOPHLETBITIS /BLOOD CLOTS	☐	☐	DIABETES	☐	☐	FREQUENT EAR PROBLEMS
☐	☐	RHEUMATIC FEVER/ HEART MURMUR	☐	☐	THYROID PROBLEMS	☐	☐	FREQUENT NASAL BLEEDING
☐	☐	CHEST PAIN	☐	☐	HEPATITIS/ JAUNDICE	☐	☐	SKIN PROBLEMS REQUIRING MEDS
☐	☐	SHORTNESS OF BREATH	☐	☐	KIDNEY DISEASE	☐	☐	MENTAL ILLNESS
☐	☐	ASTHMA/ EMPHYSEMA/ WHEEZING	☐	☐	BLOODY STOOL	☐	☐	BREAST LUMPS OR DISCHARGE
☐	☐	COLLAGEN VASCULAR DISEASE	☐	☐	BOWEL OBSTRUCTIONS	☐	☐	BREAST IMPLANTS
☐	☐	PNEUMONIA	☐	☐	STOMACH ULCERS	☐	☐	HERNIA OF: _____
☐	☐	BACK OR NECK INJURIES	☐	☐	BLADDER INFECTION	☐	☐	CANCER OF / DATE: _____
☐	☐	COLD SORES/HERPES/SHINGLES	☐	☐	ABNORMAL X-RAY/MAMMOGRAM	☐	☐	RECENT WEIGHT LOSS OR GAIN AMOUNT:_____
☐	☐	SEXUALLY TRANSMITTED DISEASE	☐	☐	SEIZURES			

☐ ☐ INJURIES OR FRACTURES: WHERE/ WHEN: _____

☐ ☐ OTHER:_____

☐ ☐ **MEDICATIONS** (include vitamins/herbs/over-the-counter):_____

_____

☐ ☐ **ALLERGIES & SIDE EFFECTS**: _____

_____

☐ ☐ **OPERATIONS/ HOPSITALIZATIONS/ ER VISITS/ COSMETIC PROCEDURES** (LIST AND DATE):_____

_____

PRIMARY CARE DOCTOR: _____ PHONE: _____ LAST EXAM : _____

GYNECOLOGIST: _____ PHONE: _____ LAST EXAM: _____

ONSET OF LAST MENSTRUAL CYCLE : (DATE)_____ ☐ Regular ☐ Irregular

NUMBER OF PREGNANCIES:_____ NUMBER OF BIRTHS:_____ METHOD OF BIRTH CONTROL:_____

COULD YOU BE PREGNANT NOW? ☐ **YES** ☐ **NO**

FAMILY HISTORY

FAMILY HISTORY OF DISEASE: LIST FAMILY MEMBER AND DATE

☐ DIABETES_____ ☐ CANCER_____

☐ STROKE_____ ☐ HYPERTENSION_____

☐ HEART DISEASE _____ ☐ OTHER_____

SOCIAL HISTORY

DO YOU SMOKE? ☐ YES / HOW MUCH? _____ ☐ NO/ DATE QUIT:_____ ☐ NEVER

DO YOU DRINK ALCOHOL? ☐ YES / HOW MUCH? _____ ☐ NO:_____

LABORATORY STUDIES (DATE AND LOCATION)

YES	NO		YES	NO	
☐	☐	BLOOD TESTS (CBC)	☐	☐	CHEST X-RAY/MRI/CT
☐	☐	EKG (CARDIOGRAM)	☐	☐	OTHER LAB_____
☐	☐	MAMMOGRAM DATE:_____	LOCATION:_____		

I CERTIFY THAT I HAVE DISCLOSED MY MEDICAL HISTORY TO THE BEST OF MY KNOWLEDGE.

_____ _____

PATIENT SIGNATURE: **DATE:<SYSTEM.DATE>**