

MEDICAL HISTORY

DATE / /

NAME (FIRST, MIDDLE, LAST)		AGE	DATE OF BIRTH
STREET ADDRESS		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
(CITY, STATE & ZIP)		HOME PHONE	
OCCUPATION		WORK PHONE	
EMERGENCY CONTACT		EMERGENCY CONTACT PHONE	
MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED			
IF MARRIED, SPOUSE'S NAME			
CHILDREN'S NAME (S) AND AGE (S)			

ALLERGIES TO MEDICATIONS, X-RAY DYES, OR OTHER SUBSTANCES YES NO
 (IF YES, PLEASE LIST THE NAME OF THE MEDICATION OR SUBSTANCE 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:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> 1. HIGH BLOOD PRESSURE | <input type="checkbox"/> 19. PNEUMONIA | <input type="checkbox"/> 37. UNEXPLAINED WEIGHT GAIN / LOSS | <input type="checkbox"/> 54. SKIN DISEASES |
| <input type="checkbox"/> 2. DIABETES | <input type="checkbox"/> 20. PERSISTENT COUGH | <input type="checkbox"/> 38. HEMORRHOIDS | <input type="checkbox"/> 55. BLOOD DISORDERS |
| <input type="checkbox"/> 3. CANCER | <input type="checkbox"/> 21. T.B. | <input type="checkbox"/> 39. GALL BLADDER DISEASE | <input type="checkbox"/> 56. VENEREAL DISEASES |
| <input type="checkbox"/> 4. HEART DISEASE | <input type="checkbox"/> 22. HAY FEVER | <input type="checkbox"/> 40. COLITIS | <input type="checkbox"/> 57. ANXIETY |
| <input type="checkbox"/> 5. CHEST PAIN / CHEST TIGHTNESS | <input type="checkbox"/> 23. ABDOMINAL DISCOMFORT | <input type="checkbox"/> 41. HEPATITIS OR JAUNDICE | <input type="checkbox"/> 58. DEPRESSION |
| <input type="checkbox"/> 6. SHORTNESS OF BREATH | <input type="checkbox"/> 24. INDIGESTION | <input type="checkbox"/> 42. THYROID DISEASE | <input type="checkbox"/> 59. ANEMIA |
| <input type="checkbox"/> 7. SWOLLEN ANKLES | <input type="checkbox"/> 25. NAUSEA | <input type="checkbox"/> 43. HEAD OR NECK RADIATION | <input type="checkbox"/> 60. ALCOHOL ABUSE |
| <input type="checkbox"/> 8. PALPITATIONS | <input type="checkbox"/> 26. VOMITING | <input type="checkbox"/> 44. HEADACHE | <input type="checkbox"/> 61. DRUG ABUSE |
| <input type="checkbox"/> 9. LIGHTEADEDNESS | <input type="checkbox"/> 27. CONSTIPATION | <input type="checkbox"/> 45. KIDNEY DISEASES | <input type="checkbox"/> 62. GOUT |
| <input type="checkbox"/> 10. FREQUENT URINATION | <input type="checkbox"/> 28. DIARRHEA | <input type="checkbox"/> 46. KIDNEY STONES | <input type="checkbox"/> 63. COUGHING BLOOD |
| <input type="checkbox"/> 11. RHEUMATIC FEVER | <input type="checkbox"/> 29. BLOOD IN STOOL | <input type="checkbox"/> 47. DIFFICULTY URINATING | <input type="checkbox"/> 64. CHANGE IN APPETITE |
| <input type="checkbox"/> 12. ASTHMA | <input type="checkbox"/> 30. ULCERS | <input type="checkbox"/> 48. PAINFUL BOWEL MOVEMENT | <input type="checkbox"/> 65. INSOMNIA |
| <input type="checkbox"/> 13. BREAST MASSES / DISCHARGE | <input type="checkbox"/> 31. URINATE AT NIGHT | <input type="checkbox"/> 49. BLOOD IN URINE | <input type="checkbox"/> 66. RINGING IN EARS |
| <input type="checkbox"/> 14. DEAFNESS | <input type="checkbox"/> 32. WEAKNESS | <input type="checkbox"/> 50. NASAL DISCHARGE | <input type="checkbox"/> 67. TINGLING/NUMBNESS |
| <input type="checkbox"/> 15. MUSCLE PAIN | <input type="checkbox"/> 33. URINARY INCONTINENCE | <input type="checkbox"/> 51. DEFORMITIES | <input type="checkbox"/> 68. SORENESS OF THROAT |
| <input type="checkbox"/> 16. URINARY INFECTIONS | <input type="checkbox"/> 34. POST NASAL DRIP | <input type="checkbox"/> 52. ARTHRITIS | <input type="checkbox"/> 69. OTHER (PLEASE SPECIFY): |
| <input type="checkbox"/> 17. NECK STIFFNESS | <input type="checkbox"/> 35. DIFFICULTY SWALLOWING | <input type="checkbox"/> 53. LOW BACK PROBLEMS | |
| <input type="checkbox"/> 18. BRONCHITIS | <input type="checkbox"/> 36. CHANGE IN BOWEL HABITS | | |

GYNECOLOGIC AND OBSTETRIC HISTORY

AGE AT ONSET OF PERIODS:	FREQUENCY:	LENGTH OF PERIOD:
PREGNANCIES:	BIRTHS:	MISCARRIAGES:
PROLONGED OR ABNORMAL BLEEDING:	<input type="checkbox"/> NO <input type="checkbox"/> YES (PLEASE DESCRIBE):	
LEAKAGE OF URINE:	<input type="checkbox"/> NO <input type="checkbox"/> YES (PLEASE DESCRIBE):	
PELVIC PAIN:	<input type="checkbox"/> NO <input type="checkbox"/> YES (PLEASE DESCRIBE):	
ABNORMAL DISCHARGE:	<input type="checkbox"/> NO <input type="checkbox"/> YES (PLEASE DESCRIBE):	
HISTORY OF ABNORMAL PAP SMEAR:	<input type="checkbox"/> NO <input type="checkbox"/> YES (TYPE OF TREATMENT):	

NEXT HISTORY DUE:

PREVENTION

DO YOU WEAR SEATBELTS?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	IF NO, WHY NOT?
DO YOU WEAR A BIKE HELMET?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> N/A
DO YOU OR HAVE YOU EVER SMOKED?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	IF YES, # OF PACKS PER DAY # OF YEARS DATE QUIT
DO YOU DRINK ALCOHOLIC BEVERAGES?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	IF YES, HOW MUCH PER WEEK?
COFFEE?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	IF YES, HOW MANY CUPS PER DAY?
TEA?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	IF YES, HOW MANY GLASSES PER DAY?
IS THERE A GUN IN YOUR HOME?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	IF YES, IS IT OUT OF CHILDREN'S REACH AND UNLOADED?
DO YOU USE DRUGS? (MARIJUANA, COCAINE, CRACK, ETC.)	<input type="checkbox"/> NO	<input type="checkbox"/> YES	IF YES, EXPLAIN:
HAVE YOU EVER ENGAGED IN ANY ACTIVITY WHICH HAS PUT YOU AT RISK OF GETTING AIDS?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	IF YES, EXPLAIN:
DO YOU WISH TO BE TESTED FOR AIDS?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	
HAVE YOU EVER WORKED WITH CHEMICALS, PAINTS, ASBESTOS, OR ANY OTHER HAZARDOUS MATERIAL?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	IF YES, EXPLAIN:
ARE YOU IN A RELATIONSHIP IN WHICH YOU HAVE BEEN PHYSICALLY HURT (E.G., SLAPPED, KICKED, PUNCHED, BRUISED) BY YOUR PARTNER?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	DO YOU EVER FEEL AFRAID OF YOUR PARTNER? <input type="checkbox"/> NO <input type="checkbox"/> YES
DO YOU USE A SUN SCREEN?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	
DO YOU HAVE A "LIVING WILL" / ADVANCED DIRECTIVE?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> FORM GIVEN
DO YOU HAVE A DONOR CARD?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	
METHOD OF BIRTH CONTROL:			