

PATIENT MEDICAL HISTORY FORM

DATE: _____ NAME: _____

MEDICATIONS (List dosages/frequency): _____

ALLERGIES/REACTIONS: _____

FAMILY DR NAME: _____

REFERRING DR NAME (If applicable): _____

YOUR PAST MEDICAL HISTORY:

Please mark an X beside condition, if applicable

| | | |
|--------------------------|---|------------|
| <input type="checkbox"/> | Cancer _____ | Type _____ |
| <input type="checkbox"/> | Heart Disease or condition | _____ |
| <input type="checkbox"/> | Mitral valve prolapse | _____ |
| <input type="checkbox"/> | High blood pressure | _____ |
| <input type="checkbox"/> | Diabetes | _____ |
| <input type="checkbox"/> | Thyroid disorder | _____ |
| <input type="checkbox"/> | Blood clotting disorder / Bleeding tendency | _____ |
| <input type="checkbox"/> | Anemia | _____ |
| <input type="checkbox"/> | Hepatitis | _____ |
| <input type="checkbox"/> | Liver disease or problem | _____ |
| <input type="checkbox"/> | Asthma | _____ |
| <input type="checkbox"/> | Pneumonia | _____ |
| <input type="checkbox"/> | Tuberculosis | _____ |
| <input type="checkbox"/> | Lung disease | _____ |
| <input type="checkbox"/> | Stomach disorder/disease | _____ |
| <input type="checkbox"/> | Colonoscopy, if applicable | _____ |
| <input type="checkbox"/> | Peptic ulcer disease | _____ |
| <input type="checkbox"/> | Epilepsy | _____ |

YOUR SOCIAL HISTORY:

Do you smoke? YES NO
How many packs per day? _____
How long have you smoked? _____

Do you drink alcohol? YES NO
If yes, how much? _____

Do you use or have you used street drugs? YES NO
If yes, what do or did you use? _____

Marital Status _____

Occupation: _____

History of domestic violence/sexual abuse? YES NO

Are you on a specific diet? YES NO
If yes, what type of diet? _____

Do you have any activity limitations? YES NO
If yes, what type of limitations? _____

Do you exercise regularly? YES NO
If yes, what type of exercise? _____

PAST MEDICAL HISTORY (continued):

Please mark an X beside condition, if applicable _____

| | | |
|--------------------------|-----------------------|----------------------|
| <input type="checkbox"/> | Neurological disorder | _____ |
| <input type="checkbox"/> | Muscle/bone disorder | _____ |
| <input type="checkbox"/> | Arthritis | _____ |
| <input type="checkbox"/> | Migraines | _____ |
| <input type="checkbox"/> | Depression | _____ |
| <input type="checkbox"/> | High cholesterol | _____ |
| <input type="checkbox"/> | Major Injury _____ | Type of injury _____ |
| <input type="checkbox"/> | Other _____ | _____ |

PAST SURGICAL HISTORY:

Appendectomy _____

Tonsil and adenoid removal _____

Gallbladder removal _____

Hysterectomy _____

Without removal of tubes & ovaries _____

With removal of TUBES RT LT BOTH _____

OVARIES RT LT BOTH _____

Reason for Hysterectomy? _____

Bladder repair _____

Tubal Ligation _____

Laparoscopy _____

D & C _____

Other surgical procedures? _____

 (Bone / Joint / Abdominal / Other)

FAMILY HISTORY:

| | | |
|---------------------|-------|--|
| | | Relationship |
| High blood pressure | _____ | _____ |
| Diabetes | _____ | _____ |
| Heart disease | _____ | _____ |
| Cancer | _____ | What type? _____ |
| | | (For example; Breast, Uterine, Ovarian, Colon) |
| | | Relationship _____ |
| Twins | _____ | |
| Other | _____ | |

GYNECOLOGICAL HISTORY:

What is the age menstruation began? _____

Days between periods _____

Length of period flows _____

Pain with periods YES NO

At what age did menopause occur? _____

What is the age sexual activity began? _____

Number of sexual partners in lifetime? _____

Abnormal pap smear YES NO

If yes, follow-up? COLPOSCOPY CONE BIOPSY

LEEP CRYO

Do you have endometriosis? YES NO

Have you been diagnosed with infertility? YES NO

Urinary Incontinence _____

Gynecological/Female Disorder _____

Gonorrhea ___ Trichomonas ___ Chlamydia ___

Syphilis ___ Herpes ___ Genital Warts ___

HIV ___ HPV ___

PREGNANCY HISTORY:

Number of Pregnancies: _____ Births _____ Miscarriages _____ Abortions _____

Number of Vaginal Deliveries _____ C-Sections _____ Reason for C-Section _____

Complications in pregnancy? _____

Complications with delivery? _____

What was weight of largest baby delivered vaginally? _____