Medical History **Date** _____

Name_____ **Date of Birth** _____

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

Past Medical History: Please circle if you *are being or have been* treated for any of the following:

Arthritis	Asthma	Ulcers	Kidney Disease/Stones	Blood Clots
Diabetes	Pneumonia	Anemia	High Blood Pressure	Migraine
Cancer	Tuberculosis	Polyps	Gallblader Disease	Gout
Heart Disease	Hay Fever	Liver Disease	Alcohol Abuse	Anxiety
Rheumatic Fever	Allergies	Thyroid Disease	Substance Abuse	Depression
HIV/AIDS	Hepatitis	Colitis	Skin Disease	Other_____
Blood Disorders			Venereal Diseases	

Have you ever had:

Stress Test Y N If yes, date_____ Cardiac Cath. Y N If yes, date_____

Flex Sig. Y N If yes, date_____ Colonoscopy Y N If yes, date_____

Endoscopy Y N If yes, date_____

When was your last:

Cholesterol Check_____ Stool Check for Blood_____ Prostate Check_____

Review of Systems: Please circle if you are *currently* having any of the following:

General:

Weight Loss / Gain	Fever	Sleep Apnea	Loss of Appetite	Rash	Fatigue
Anxiety	Depression	Sleep Disturbance	Sleepiness During Daytime	Chills	Insomnia
Easy Bruising	Skin Lesions	Other_____			

Neurological:

Headaches	Numbness	Changes in Hearing	Changes in Vision	Last Eye Exam _____
Tingling	Dizziness	Lightheadedness	Changes in Gait	

Cardiovascular:

Chest Pain	Palpitations	Heart Murmur: Do you take antibiotics before dental exams? Y N
Shortness of Breath	Swollen Ankles	

Respiratory

Wheezing	Shortness of	Nasal Discharge? Y N	If yes, color_____
Painful Breathing	Breath	Cough? Productive? Y N	If yes, color_____

Gastroinstestinal:

Indigestion	Rectal Bleeding	Black / Tarry Stools	Change in Bowel Habits	Heartburn	Reflux
Abdominal pain	Nausea	Vomiting	Hemorrhoids		

Genitourinary:

Frequency	Burning with Urination	Getting Up During the Night to Urinate
Urgency	Changes in Sex Drive	Incontinence: stress or urge
	Erectile Dysfunction	

Musculoskeletal:

Bone Pain	Joint Pain	Muscle Aches	Arthritis

Notes:

Gynecologic and Obstestric History

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

Pregnancies: _____ Births: _____ Miscarriages: _____

Are you using birth control? Y N If yes, which method?_____

Do you have any of the following:

Prolonged Bleeding Abnormal Bleeding

Leakage of Urine Pelvic pain Abnormal Discharge History of abnormal Pap Smear

When was your last: Pap Smear_____ Mammogram _____

Period_____ Breast Check_____ DEXA Scan (bone density)_____

Operations: _____

Hospitalizations (Other than for surgery)**:** _____

Lifestyle

	Yes	No		
Do you wear seatbelts?	____	____	If no, why not?	
Do you wear a bike helmet?	____	____	____ n/a If no, why not?	
Do you exercise regularly?	____	____	If yes, type & duration per week	
Do you smoke / chew tobacco?	____	____	If yes, how many packs per day?	
Do you drink alcoholic beverages?	____	____	If yes, how much per week?	
Do you drink tea?	____	____	If yes, how many cups per day?	
Do you drink coffee?	____	____	If yes, how many cups per day?	
Do you wish to be tested for AIDS?	____	____		
Do you have a living will?	____	____		
Have you had blood tranfusions?	____	____		

Immunization History: Have you had any of the following:

Hepatitis A Y N Date_____ Hepatitis B Y N Date_____

Pneumovax Y N Date_____ Flu Y N Date_____

Tetanus Y N Date_____ Other _____

Past Family History: Have any members of your family (parents, grandparents, & siblings) ever had any of the following?

Illness	Family Member(s)	Age Diagnosed
Cancer		
Hypertension (High Blood Pressure)		
Heart Disease		
Diabetes		
Strokes		
Mental Disease (Anxiety/Depression)		
Drug or Alcohol Addiction		
Glaucoma		
Bleeding Diseases		
Other: _____		