Medical History

Today's Date: / /

Name: **Chart #**

Medications (Prescription, Over the Counter, Vitamins, Herbs, etc.) ❑ **None**

Drug name	How many times a day?	mg (Dosage)	Drug name	How many times a day?	mg (Dosage)

Past and Current Medical History

Please place "X" on any problems you have had in the past or problems you are having currently.

1 __ High blood pressure
2 __ High cholesterol
3 __ Diabetes
4 __ Asthma
5 __ Allergies/allergic rhinitis/Hay fever
6 __ Cancer
7 __ Heart disease
8 __ Ulcers
9 __ Hemorrhoids
10 __ Colitis
11 __ Hepatitis
12 __ Hyperthyroidism (too much thyroid hormone)
13 __ Hypothyroidism (too little thyroid hormone)
14 __ Migraines
15 __ Kidney diseases
16 __ Arthritis
17 __ Low back pain
18 __ Anxiety
19 __ Depression or __ **NONE**
20 __ Anemia
21 __ Alcohol abuse
22 __ Drug abuse
23 __ Gout
24 __ Other, please name.

Do you have allergies to any medication?

❑ No ❑ Yes If yes, fill out below.

Medication	Symptom
1	
2	
3	
4	

Have you had any operations?

❑ No ❑ Yes If yes, fill out below.

	Year
Tonsillectomy	
Hernia Repair	
Wisdom Teeth Removal	
Other:	

Have you ever been hospitalized overnight?

(ER visits without admission or Child Birth do not count.)

❑ No ❑ Yes If yes, fill out below.

Problem	Year

Did/do your relatives have any medical problems?

For Example…. Cancer, High Blood Pressure, Diabetes, Stroke, Heart attack, Depression

Relative	Year of Birth			Problems (year started)
Father		❑ No	❑ Yes	1. ( ) 2. ( ) 3. ( )
Mother		❑ No	❑ Yes	1. ( ) 2. ( ) 3. ( )
Brothers		❑ No	❑ Yes	1. ( ) 2. ( ) 3. ( )
Sisters		❑ No	❑ Yes	1. ( ) 2. ( ) 3. ( )
Paternal Grand Father		❑ No	❑ Yes	1. ( ) 2. ( ) 3. ( )
Paternal Grand Mother		❑ No	❑ Yes	1. ( ) 2. ( ) 3. ( )
Maternal Grand Father		❑ No	❑ Yes	1. ( ) 2. ( ) 3. ( )
Maternal Grand Mother		❑ No	❑ Yes	1. ( ) 2. ( ) 3. ( )

NEXT PAGE PLEASE

Medical History

Today's Date: / /

List your children and the year they were born. ❑ **None**

	Child Name	Gender M/F	Birth Year	Medical Problem No/Yes (explain)
1		M/F		❑ No ❑ Yes
2		M/F		❑ No ❑ Yes
3		M/F		❑ No ❑ Yes
4		M/F		❑ No ❑ Yes

Complete your Social History.

1 Are you a : ❑ never smoker---skip to question #2 ❑ former smoker ❑ current smoker

* If **former smoker**, how long has it been since you last smoked?

❑ <1 month ❑ 1~3 months ❑ 3~6 months ❑ 6~12 months ❑ 1~5 yrs ❑ 5~10 yrs ❑ >10 yrs

* If **current smoker**, do you smoke everyday? ❑ No ❑ Yes

* If **current smoker**, how many cigarettes a day do you smoke? ______________________

* If **current smoker**, when is your first cigarette from the time you wake up in the morning?

❑ 5min ❑ 6~30min ❑ 31~60min ❑ after 60min

* If **current smoker**: ❑ You are ready to quit. ❑ Thinking about quitting. ❑ Not ready to quit.

* If **current smoker**, would you like us to fax your information to a smoking counselor to help? ❑ No ❑ Yes

2 Did you have a drink containing alcohol in the past year ? ❑ No---skip to question #3 ❑ Yes

* If yes, how often did you have a drink containing alcohol in the past year?

❑ Never ❑ Monthly or less ❑ 2~4 times a month ❑ 2~3 times a week ❑ 4 or more times a week

* If yes, how many drinks did you have on a typical day when you were drinking in the past year?

❑ 1~2 ❑ 3~4 ❑ 5~6 ❑ 7~9 ❑ 10 or more

* If yes, how often did you have 6 or more drinks during one occasion in the past year?

❑ Never ❑ Less than monthly ❑ Monthly ❑ Weekly ❑ Daily or almost daily

3 Do you use drugs? (marijuana, cocaine, crack, etc.) ❑ No ❑ Yes **If yes, explain:** ______________

4 What is your occupation? ______________________________

5 If you had sex with someone, it will be with members of the:

❑ Opposite Sex ❑ Same Sex ❑ Both ❑ Neither

6 You are ❑ Single or ❑ Married

If single, ❑ Divorced ❑ Spouse died ❑ Live with a partner ❑ None of these

7 Name of your spouse or partner, if any.

First Name Last Name

____

8 When was your last Pap Smear? ______________________

Have you ever had an abnormal Pap Smear result? ❑ No ❑ Yes **when/type** ________ / ________