MEDICAL HISTORY

Name: Age: Today's Date: Referred By:

Past Medical & Family History - *Please check if you (Pers) or any blood relative (Fam) had any of the following conditions...*

	Pers	Fam	Children				Per	Fam
			Yr.of birth	Sex	Birth Wt.			
1. Wt. Loss-Gain	☐		________	____	________	13. Urinary Infections	☐	☐
2. Headaches / Migraine	☐		________	____	________	14. Blood Transfusions	☐	
3. Heart Disease ☐	☐	☐	________	____	________	15. Anemia / Blood Disorder	☐	
Valvular Dis ☐			________	____	________	16. Acne-Complexion Problem	☐	☐
Rheumatic Dis ☐						Skin Disease (Other)	☐	☐
4. High Blood Pressure	☐	☐				17. Diabetes	☐	☐
5. High Cholesterol	☐	☐				18. Thyroid Disease	☐	☐
6. Respiratory (Lung) Disease	☐	☐				19. Cancer (Type)	☐	☐
7. Breast Disease	☐	☐	Type of	C-Sect. or		20. Epilepsy / Seizures	☐	☐
8. Jaundice / Hepatitis	☐	☐	Anesthesia	Vaginal Delv.		21. Arthritis - Joint Pain	☐	☐
9. Hiatal Hernia (Reflux)	☐	☐	____________	____________		22. Anxiety / Depression	☐	☐
10. Peptic Ulcer (Stomach)	☐	☐	____________	____________		23. Sleep Problems	☐	☐
11. Bowel Disease	☐	☐	____________	____________				
12. Kidney Disease	☐	☐	____________	____________				

Hospital Admissions - *List those operations & serious illnesses which required hospitalization (excluding pregnancy)*

Year	Reason For Admission / Hospital	Year	Reason For Admission / Hospital

Medications -List all medications you are currently taking (dosag-frequency)-include over the counter drugs, vitamins & hormones

Drug Allergies:

Obstetrical History # of Pregnancies: Premature Babies: Miscarriages: Abortions: Living Children:

Current Obstetrics If you are pregnant, do you plan to breastfeed? Y N Blood Type:
If RH negative, have you received Rhogam? Y N
Pediatrician: Family Doctor:

Menstrual History Age at first period? If menstruating, date of last period (1st day)?

Periods are: ☐ Regular ☐ Somewhat Irregular ☐ Completely Irregular

Period Interval: (1st day to 1st day) Number of days? _____ Duration of Bleeding? From___to___days

Bleeding (spotting) in between periods? Y N

With your periods do you have? - ☐ Pain ☐ Cramps ☐ Bloating

Time lost from school / work because of periods? Y N

Birth Control Current Method: How Long? If pill, brand? Past Methods:

Comments / Problems:

Sexual History Are you sexually active? Y N Is intercourse satisfactory? Y N Pain / bleeding with intercourse? Y N
Wish to discuss? Y N

Pelvic Exam Date of last exam: **Pap Test** Date of last test: ☐ Normal ☐ Abnormal

Infections At present - any abnormal vaginal discharge? Y N **History of**: ☐Yeast Infections ☐ Chlamydia ☐ Gonorrhea ☐ Trichomanas ☐ Herpes ☐ Bacterial Infection ☐ Bladder / Urinary Infections

Breasts ***Do you*** - Routinely check your breasts? Y N Have any - ☐ Painful ☐ Tender or ☐ Lumpy Breasts?
Have any nipple discharge? Y N Have any other concerns? Y N

Social History Smoking-Pack/Day # of years Alcohol-glasses/wk Coffee-cups/day Street Drugs-

Patient Signature

Doctor's Signature