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Patient Name: _____ Acct: _____

PERSONAL MEDICAL HISTORY

Reason for visit:_____

Drug Allergies:_____

Smoker: □ Yes □ No Alcohol Use: □ Yes □ No

Current Medication: SEE LIST

Surgical History/Illness/Injuries:_____

_____

Menstrual Cycle:

Last Menstrual Period:_____ Age of 1st Period:_____
Days between period:_____ Days Period lasts:_____
Cramps: □ Yes □ No Medication:_____
Other problems with periods:_____

Pregnancy History:

#Of pregnancies: _____ # Of children:_____
Types of Deliveries: □ Vaginal #_____ □ C/Section #_____
Of Miscarriages:_____ Abortions:_____
Of Multiple Pregnancies:_____ Tubal Pregnancies:_____
Any Complications: _____

Patient Name:_____ Acct# _____

Check all that apply to you:

□ Asthma
□ Anemia
□ Blood Clots
□ Breast Disease/Surgery
Date:_____
_____
□ Cancer
Date:_____
_____
□ Diverticulosis
□ Drug Dependency
□ Diabetes/Low Blood Sugar
□ Elevated Cholesterol
□ Epilepsy/Seizures
□ Gallbladder
□ Headaches
□ Heart Problems
□ Hepatitis
□ Hiatal Hernia
□ High Blood Pressure
□ Infection of Tubes/Ovaries
□ Kidney Disease
□ Liver Disease
□ Mammogram
Date:_____
□ Mental Depression
□ Neurologic Problems
□ Pap Smear
Date:_____
Problems:_____
_____
□ Rheumatic/Scarlet Fever
□ Symptoms of Stroke
□ Sickle Cell Anemia
□ Thrombophlebitis
□ Thyroid Disease
□ Urinary Tract Infection
□ Varicosities
□ Vaginal Infections:
□ Chlamydia
□ Gardnerella
□ Gonorrhea
□ Herpes
□ Syphilis
□ Trichomonas
□ Warts
□ Yeast
□ Other_____

Family Medical History:

□ Cancer _____
□ Diabetes _____
□ Heart Disease _____
□ High Blood Pressure _____
□ Kidney Disease_____
□ Lung Disease_____
□ Mental Illness_____
□ Stroke _____
□ Other _____

_____ _____

Patient Signature Date