PATIENT MEDICAL HISTORY

DATE: _____

1. SOCIAL HISTORY

Name: _____ Birthdate _____/_____/_____
(Last) (First) (M.I)

Occupation: _____
Marital Status ____ Spouse's Name: _____ Children: _____
(Names & Ages)

Special cultural beliefs that might affect your healthcare _____
Do you have Power of Attorney for healthcare? ____ Yes ____ No Do you have a living will? ____ Yes ____ No

Use of home health or other community services? ____ Yes ____ No
Name of other Health Care Providers: _____

2. PAST MEDICAL HISTORY

Have you ever had the following, if so, when?

____ Alcoholism	____ Coronary Heart Disease	____ High/Low Blood Pressure	____ Rheumatic Fever
____ AIDS/ related complex	____ Diabetes	____ Kidney Disease	____ Sexually Transmitted Disease
____ Anemia	____ Emotional Problems	____ Liver Disease / Hepatitis	____ Stomach/ Intestinal Disease
____ Asthma	____ Epilepsy / seizures	____ Migraines	____ Stroke/ Paralysis
____ Bone/ joint problems	____ Gallbladder	____ Pleurisy	____ Thyroid Disease
____ Cancer (type) _____	____ High Cholesterol/ Lipids	____ Pneumonia	____ Tuberculosis

3. HOSPITALIZATIONS

Have you ever been hospitalized? ____ Yes ____ No (If so, please list)

_____

Have you had? ____ Appendectomy ____ Tonsillectomy _____ Cholecystectomy (Gallbladder)

Other surgeries: _____

4. FAMILY HISTORY

Has any blood relative ever had: Check all that apply and their relationship to you.

Alcoholism	Kidney Disease
Anemia	Memory Loss
Asthma	Mental Illness
__ Bleeding Problem _____	__ Thyroid Disease _____
__ Cancer, type _____	__ Osteoporosis _____
__ Diabetes _____	__ Stroke _____
__ Heart Disease _____	__ Substance Abuse _____
High Blood Pressure	Tuberculosis
__ High Cholesterol _____	__ Other: _____

5. MEDICATIONS

Also includes any over-the-counter medications such as vitamins, antihistamines, Tylenol, herbal remedies, etc.

_____ _____ _____
_____ _____ _____

6. ALLERGIES

Please check items to which you are allergic

____ Drug Allergies: (specify) _____
____ Food/Environmental: (specify) _____
____ Iodine / Shellfish ____Bee Stings / Insect Bites ____ X-ray / Arteriogram or dyes ____ Adhesive tape ___ Latex ___ Peanuts
____ Other allergies: (specify)

7. IMMUNIZATIONS Check those that you have had. (Please note the most recent year received)

____ Usual Childhood Immunizations _____ ____ Flu _____ ____ Pneumonia _____ ____ Tetanus _____

____ Chicken Pox _____ ____ Hepatitis _____ ____ Others _____

8. HEALTH MAINTENANCE

Last Dental Exam: ____/____/____ Last Vision Exam: ____/____/____ Last Rectal Exam/ Colonoscopy: ____/____/____

9. HABITS

Do you exercise regularly? ____ Yes ____ No Type? _____ How long? _____ How Often? _____

Do you drink caffeinated beverages? ____ Yes ____ No How much? _____ Daily/ Weekly

Do you drink alcoholic beverages? ____ Yes ____ No How much? _____ Daily/ Weekly
Type? _____ How long? _____

Do you now, or have you ever used: ____ Cigarettes (Packs/Day ____ x ____ Years) ____ Pipe x ____ years

____ Chewing Tobacco x ____ years ____ Cocaine x ____ years ____ IV Drugs x ____ years ____Marijuana x ____ years

Do you regularly use a seat belt? ____ Yes ____ No

10. SEXUAL HISTORY (Men & Women)

Are you sexually active? ____ Yes ____ No Lifetime number of partners _____

Current contraception method or protection against STDs: _____

11. MEN ONLY

Last rectal exam: ___/____/___ Last PSA: ___/___/___ Practice monthly testicular exam? __Yes __ No __ Need information

Difficulty urinating? ____ Yes ____ No

12. WOMEN ONLY

Last menstrual cycle: ____/____/___

Age at onset: _____ ___ Regular ___ Irregular

Flow: ____ Heavy ____ Moderate ____ Light
Pain/cramps with menses: ____ Yes ____ No

Days of flow: _____ Length of cycle: _____

Last Pap smear: ____/____/____
Last Mammogram ____/____/___
Monthly self-breast exam ____ Yes ____ No
Menopause ____ Yes ____ No Age: _____

Pain/bleeding after sex: ____ Yes ____ No

Pregnant: ____ Yes ____ No

Number of pregnancies: _____
Number of ectopic pregnancies: _____

Number of live births: _____

Number of miscarriages: _____ Number of abortions: _____
Contraception method: _____
Name of birth control: _____

Symptoms of menopause: _____

Please list any general concerns: _____

Print Name: _____

Patient Signature: _____Date: _____/_____/_____

I have reviewed, and/or made changes as necessary to this form.

Provider Signature: _____