MEDICAL HISTORY

Name *(First Last)*:_____ **Today's Date:** _____

Date of Birth: _____ **Gender:** ❑ Male ❑ Female

Welcome!
We appreciate your time and consideration in completing this Medical History Form.
This information will become part of your confidential Medical Record.

Medical Problems *(Please check all that apply)*

❑ Heart Problems
❑ Lung Problems
❑ Kidney Problems
❑ Urinary Complaints
❑ Stomach Problems
❑ Eye Problems
❑ High Blood Pressure
❑ Nervous System Disorders
❑ Liver Disease/Hepatitis
❑ Gallbladder Disease
❑ Bleeding/Blood Problems
❑ Anxiety Disorder
❑ Reproductive Disorders
❑ Depression
❑ Diabetes
❑ Stroke
❑ Sinus Infection
❑ Allergies
❑ Headaches
❑ Cancer
❑ Ear Problems

Please comment on checked items, or others not listed: _____

_____

_____

Screenings

Have you ever had a Colonoscopy? ❑ Yes ❑ No If yes, what date? _____/_____/_____

Surgeries and Hospitalizations

Surgery/Hospitalization Reason	Date	Location
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Immunizations *Please list dates of last known immunizations*

Shingles: ____/____/____ Tetanus: ____/____/____ Pneumonia: ____/____/____ Flu: ____/____/____

Family History *(Please list any disease which runs in your family. Please specify age of onset or death and relationship to those relatives named.)*

_____

_____

_____

Social History *(Please write "N/A" for non-applicable)*

Hobbies/Interests: _____

Means of Exercise: _____

Do you smoke or chew tobacco?

❑ Yes If yes, how much? _____ How many years? _____

❑ No If no, have you ever? _____ When did you quit? _____/_____/_____

Do you drink alcohol?

❑ Yes ❑ No If yes, how often? ❑ Daily ❑ Rarely ❑ Occasionally

If yes, what types? ❑ Beer ❑ Wine ❑ Hard Liquor

Do you use recreational drugs? ❑ Yes ❑ No If yes, what types? _____

Have you ever used intravenous drugs? ❑ Yes ❑ No

Have you ever received blood or a blood products transfusion? ❑ Yes ❑ No

Sexual and Reproductive History

Female Patient

Do you practice safe sex? ❑ Yes ❑ No

Do you have multiple partners? ❑ Yes ❑ No

Mode of birth control *(Check all that apply)*

❑Abstinence ❑Pill ❑ Condoms

❑Diaphragm ❑Tubal Ligation

❑Other: _____

Have you ever had a sexually transmitted disease?

Yes No If yes, *please check all that apply*:

❑Gonorrhea ❑Herpes ❑ Chlamydia

❑ Syphilis ❑Genital Warts

Do you or any sexual partner have HIV?

❑ Yes ❑ No

Do you suffer from any of the following conditions?

❑ Vaginal Discharge ❑ Vaginal Itching

❑ Urinary Incontinence ❑ Bowel Incontinence

Prolapse of the: ❑ Uterus ❑ Bladder ❑ Rectum

Age of first menstrual period: _____

Usual duration: _____ Frequency: _____

Regular? ❑ Yes ❑ No

Please list your number of:

Pregnancies _____ Births _____

Miscarriages_____ D & Cs_____

Elective Abortions_____

Date of last pap: _____/_____/_____

Date of last mamo: _____/_____/_____

Any abnormalities? _____ Year? _____

Treatment: _____

Male Patient

Do you practice safe sex? ❑ Yes ❑ No

Do you have multiple partners? ❑ Yes ❑ No

Mode of birth control *(Check all that apply)*

❑ Abstinence ❑ Condoms ❑ Vasectomy

❑ Other: _____

Have you ever had a sexually transmitted disease?

❑ Yes ❑ No If yes, *please check all that apply*:

❑ Gonorrhea ❑ Herpes ❑ Chlamydia

❑ Syphilis ❑ Genital Warts

Do you or any sexual partner have HIV?

❑ Yes ❑ No

Do you suffer from any of the following conditions?

❑ Impotence ❑ Urethral Discharge

❑ Weak Stream ❑ Urinary Frequency

❑ Urinary Dribbling

Current Medications *(Including Oxygen and inhalers)*

Name of Medication	Strength	Directions

Vitamins and Supplements

Name of Medication	Strength	Directions

Allergies

Medication	Reaction	Food/Other Allergies	Reaction

Health Care Preferences

Preferred Pharmacy: _____

	Provider Name	Location
Dentist:		
Eye Doctor:		
Specialist(s):		