

MEDICAL HISTORY FORM – Please answer all questions or mark N/A if non-applicable to you

Patient Name: _____ **Birthdate:** ____/____/____ **Date:** _____

Race: _____ **Ethnicity:** _____ **Primary Language:** _____

Reason for visit: _____

Allergies – Do you have any drug allergies? Yes / No (Circle)			
Drug	Reaction	Drug	Reaction

Are you allergy to Latex, Iodine or Contrast Dye? Yes / No **What reaction?** _____

Please list all Medication taken: (Continue on back if necessary)

Drug	Dosage(mg)	Number of times taken per day	Drug	Dosage(mg)	Number of times taken per day

Have you ever had a blood transfusion? Yes No

Are you willing to have a blood transfusion in order to save your life? Yes No

Past Medical History: Have you ever had any of the following illnesses? Check all that apply.

- Heart Trouble Osteoporosis Breast Problems Nipple Discharge Diabetes
- Kidney Bladder Problems Anemia Hemorrhoids Anesthesia Problems
- High Blood Pressure Endometriosis Rectal Bleeding Antibiotics for Dental work
- Bleeding Problems Fibroids Heart Murmur MVP High Cholesterol
- Thyroid Problems Pelvic Prolapse Anxiety Blood Disorders
- Depression Polycystic ovarian syndrome Seizures
- Bowel Problems Ulcer Stomach Trouble Alcohol/Drug Abuse
- Lung Disease (i.e. Asthma) Blood clots in arms/legs or lungs Pelvic Prolapse
- Cancer (type) _____ (age) _____ Other _____

Pap Smear History : **When was your last pap smear?** _____ **Where was it done?** _____

Was your last pap smear normal? Yes No

Have an abnormal one? Yes No **Treatment?** Colposcopy Leep CKC Other

Breast History : **When was your last mammogram?** _____ Never

Have you ever had breast problems? Yes No **What problems?** _____

Do you have breast implants? Yes No

Surgical History: Please list all surgeries (medical & cosmetic) including hospitalizations

Date	Procedure	Date	Procedure

FAMILY HISTORY: (Please check if any of your family members have had the following; please include which relative)

	Mother	Father	Brother	Sister	Mom's Mother	Dad's Mother	Mom's Father	Dad's Father	Aunt	Uncle
Breast Cancer										
Colon Cancer										
Ovarian Cancer										
Other Cancer Please Specify:										
Heart Disease										
High Blood Pressure										
Diabetes										
Stroke										
Other Please Specify:										

Social History Please check box and fill in the blanks	
Y / N	Alcohol – Type: <input type="checkbox"/> Occasionally <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy
Y / N	Tobacco – Type: Amount per day: <input type="checkbox"/> Former smoker
Y / N	Illegal drugs – Type: Amount per day:
	Religion:
	Marital History: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
	Living situation: <input type="checkbox"/> alone <input type="checkbox"/> with spouse <input type="checkbox"/> with partner <input type="checkbox"/> with parents / custodian <input type="checkbox"/> with children <input type="checkbox"/> at school <input type="checkbox"/> other
	Age 17 & Under: Diet <input type="checkbox"/> Well Balanced <input type="checkbox"/> Poorly Balance / Exercise <input type="checkbox"/> None <input type="checkbox"/> Occ . <input type="checkbox"/> Regularly X __ per week __ min.

Sexually activity: Never Not now but in past With one partner With more than one partner 5 or more partners in lifetime

Current birth control method (circle):	Pill	Patch	Ring	Shot	Partner has vasectomy	Tubal ligation
Essure	Adiana	Hysterectomy	IUD	Natural Family Planning	Abstinence	Trying to conceive
Condom use:	<input type="checkbox"/> always	<input type="checkbox"/> most of the time	<input type="checkbox"/> rarely	<input type="checkbox"/> never		

Abuse and Domestic Violence History Please check box if applies.	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Were you sexually abused or molested? <input type="checkbox"/> As a child or teen <input type="checkbox"/> As an adult
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you currently being sexually abused, threatened or hurt by anyone? Whom? _____

Patient Name: _____

Date: _____

Pregnancy/ Delivery History (please write them in the order they occurred)

PLEASE INCLUDE MISCARRIAGES, ECTOPIC & ELECTIVE ABORTIONS

	Born Month/year	Baby's Sex	Weight at Birth	Weeks Pregnant	Type of Delivery	Dr. who Delivered	Complications
1			Lbs oz				
2			Lbs oz				
3			Lbs oz				
4			Lbs oz				
5			Lbs oz				
6			Lbs oz				
7			Lbs oz				
8			Lbs oz				

Last Menstrual Cycle Date: ____/____/____ Do you think you are pregnant? Yes No

Age at onset of menses _____ Do you have bleeding between cycles Yes No

Cycles are every ____ days. Cycles last ____ days.

How heavy are your cycles? Light Moderate Heavy

When was your last flu vaccine? _____ Never

When was your last pneumonia vaccine? _____ Never

Have you ever had a bone density study? Yes No If yes, when? _____ Where? _____

Have you ever had sexually transmitted infections: Yes No

(If yes please check which one below and write year and if treated)

STI type: Chlamydia-Month/Year _____ Treatment Yes / No, Gonorrhea-Month/Year _____ Treatment Yes / No,

Hepatitis-Month/Year _____ Treatment Yes / No, HIV -Month/Year _____ Treatment Yes / No,

Genital Warts-Month/Year _____ Treatment Yes / No, Genital Herpes- Month/Year _____ Treatment Yes / No,

Syphilis- Month/Year _____ Treatment Yes / No, HPV - Month/Year _____ Treatment Yes / No,

Trichomonas- Month/Year _____ Treatment Yes / No

Patient's Signature: _____ Date: _____

Completed by (if other than patient): _____ Relationship: _____