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Patient Medical History Form

Name_____________________________________ Date of Birth ___/ ____/___ Age______ Today's Date______________

☐Single ☐Married ☐Separated ☐Divorced ☐Widowed Referred By: _________________________

List any **allergies & reactions to medications: ____ **OR**

☐ **No Known Allergies**

Medications List medication and dosages you are currently taking, including over-the-counter medications, vitamins and herbal remedies:

_________________________ ____________________________ _________________________

_________________________ ____________________________ _________________________

Family History

Please list any ***close relative*** (*indicate maternal or paternal relationship*) with a history of the following:

	Relative/Age at diagnosis		Relative
☐Breast Cancer		☐High Blood Pressure	
☐Ovarian Cancer		☐Diabetes	
☐Uterine Cancer		☐Heart Disease (heart	
☐Colon Cancer		attacks, stroke, bypass surgery)	
☐Osteoporosis		☐Sickle Cell	
☐Cystic Fibrosis		☐Tay Sachs	
☐Blood Clots		☐Muscular Dystrophy	
☐Hemophilia		☐Other Genetic Disorder	

Gyn History:

Age of first period________ Last menstrual period: _____________

Age of menopause________

Birth control: ☐Condoms ☐Vaginal ring ☐Partner with vasectomy ☐Patch ☐IUD
☐Pills ☐Tubal ☐Natural family planning ☐None ☐Other

Have you ever had any STD's? ☐Yes ☐No If yes please list which ones: ____

Have you ever had an abnormal pap smear? ☐Yes ☐No

If yes, what treatment did you receive for it: ____

OVER

Health Maintenance

Date of last pap smear_______________________ ☐Normal ☐Abnormal

Date of last mammogram_______________________ ☐Normal ☐Abnormal ☐Never had one

Date of last bone density________________________ ☐Normal ☐Osteopenia ☐Osteoporosis ☐Never had one

Date of last colonoscopy________________________ ☐Normal ☐Abnormal ☐Never had one

Obstetrical History:

☐***Check if you have NEVER BEEN PREGNANT***

# of pregnancies: __________ # of *live births*: _________

# of miscarriages:__________ # of stillbirths: ___________ # of ectopic (tubal):_________ # of abortions: ____________

# of vaginal deliveries ________ # of C-Sections:___________

Please list any complications with pregnancies: ____

☐Check if you have ***adopted*** children

Past Medical History Please check any of the following conditions/diseases you have had:

☐Arthritis	☐Diabetes	☐High Blood Pressure	☐Ulcers
☐Asthma	☐Emphysema	☐High cholesterol	☐Skin Conditions
☐Blood Clots	☐Glaucoma/Cataracts	☐ HIV/AIDS	☐Stroke
☐Cancer	☐Heart Disease	☐Inflammatory Bowel Disease	
☐Chronic Back/Joint problems	☐Headaches/Migraines	☐Kidney Disease	
☐Congestive Heart Failure	☐Head Injury	☐Seizures	
☐Depression/Emotional concerns	☐Hepatitis/Liver Disease	☐Thyroid Disease	

☐Other____

Smoking Status: Current smoker ☐ **Yes** *If yes, __________pack(s) per day ☐ **No -** choose one: ☐Never smoker ☐Former Smoker

Social History

Alcohol use	☐Yes	☐No	If yes, __________drink (s) per day/week/month
Street drug use	☐Yes	☐No	Type and frequency____
Exercise	☐Yes	☐No	Type and frequency____
Caffeine	☐Yes	☐No	If yes, _______caffeinated drinks (coffee, tea, soda) per day/week
Sexual Abuse	☐Yes	☐No	If yes, are you safe now? ☐Yes ☐No Counseling? ☐Yes ☐No
Physical Abuse	☐Yes	☐No	If yes, are you safe now? ☐Yes ☐No Counseling? ☐Yes ☐No
Emotional Abuse	☐Yes	☐No	If yes, are you safe now? ☐Yes ☐No Counseling? ☐Yes ☐No

Surgical History Please list all surgeries with dates:

____ ____

____ ____