 1200 Sixth St. Suite 400

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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:

**MEDICATION NAME DOSE HOW OFTEN**

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**Family History:**

Please list ***1st degree relative*** ***only*** (*mother, father, sister, brother, son, daughter*) with a history of the following:

**Relative**  **Relative**

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| 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 |  |
| DVT/PE |  | Muscular Dystrophy |  |
| Hemophilia |  | Other Genetic Disorder |  |

**Gyn History:**

Birth control: Condoms Pills Vaginal ring

IUD - Date inserted \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nexplanon – Date inserted \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Partner with vasectomy 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Health Maintenance:**

Last Bone Density \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Normal Abnormal Never had one

Last Colonoscopy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Normal Abnormal Never had one

Last Mammogram\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Normal Abnormal Never had one

Last Pap Smear\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Normal Abnormal

**Obstetrical History:**

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

# of pregnancies: \_\_\_\_\_\_\_\_\_\_ # of miscarriages:\_\_\_\_\_\_\_\_\_\_ # 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:

Osteo Arthritis GERD Hypertension Hypothyroid

Rheumatoid Arthritis Kidney Stones COPD Hyperthyroid

Asthma Seizure Disorder Heart Arrhythmia Thyroid Nodules

DVT/PE Glaucoma Heart Attack Breast Cancer

Chronic Back Pain Diabetes Congestive Heart Failure Ovarian Cancer

Disc Disease Migraines IBS Uterine Cancer

Depression Head Injury Ulcerative Colitis Colon Cancer

Anxiety Hepatitis/Liver Disease Crohn’s Disease

Bipolar Disorder

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Smoking Status**: Current smoker  **Yes - \****if yes*, \_\_\_\_\_\_\_\_\_\_pack(s) per day **NO -** 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*:

**SURGERY DATE**

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