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This is a confidential record of your medical history and will be kept in your chart.

Patient History Information

Have you ever had or suffer from any of the following:

___ High Blood Pressure	___ Congestive Heart Failure	___ Reflux
___ Diabetes Mellitus	___ Angina Pectoris	___ Peptic Ulcer Disease
___ High Cholesterol	___ Valvular Heart Disease	___ Diverticulosis
___ Thyroid Disease	___ Atrial Fibrillation	___ Hemorrhoids
___ Stroke	___ Irregular Heart Beat	___ Kidney Disease
___ Migraines	___ Asthma	___ Anemia
___ Arthritis	___ Tuberculosis	___ Cancer (Type_____)
___ COPD	___ Pneumonia	___ Bleeding Abnormality
___ Heart Attack	___ Bronchitis	___ Kidney Stones
___ Depression	___ Liver Disease	___ Seizures
___ Glaucoma	___ Prostate Disease	___ Urinary Tract Infection

Others not mentioned: _____

Medication Allergies: _____

Hospitalizations: _____

_____

Surgeries (Type & Date): _____

_____

Social History

Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed Number of children: _____
Occupation: _____
Do you smoke cigarettes? ___ Yes ___ No How many packs per day? _____ How long have you smoked? _____
Have you ever smoked in the past? If yes, for how long? _____
Do you chew tobacco or snuff? ___ Yes ___ No How long have you used oral tobacco? _____
Do you drink alcoholic beverages? ___ Yes ___ No Type: ___ Beer ___ Wine ___ Liquor ___ Mixed Drinks
How many drinks do you have? _____ How many years have you drank alcohol? _____
Do you or have you used illegal drugs? _____
How many caffeinated drinks do you have per day? _____
Do you have any pets? ___ Yes ___ No If yes what kind? _____
To what countries have you traveled out side of the United States? _____

Birth History

Children under 18 years old

Did mother take prenatal vitamins? ___ Yes ___ No Birth weight _____
Number days spent in the hospital? ___ Term ____ Preterm ____Post term
Type of delivery? ___ Vaginal ___ C-section ___ Forceps ____ Vacuum
Maternal complications? ___ Yes ___ No (abruption, maternal diabetes, cerclage, ect.)
Is child in daycare? ___ Yes ___ No ___ Full time ___ Part time

Family Medical History

Please list all first-degree relatives with the following illnesses:

Heart Attack: _____ Stroke: _____
Diabetes: _____ High Blood Pressure: _____
Cancer: _____ Sudden Death: _____
Other: _____
_____

Women Only

Last menstrual period: _____ Do your periods come every month? ___ Yes ___ No If no how often? _____
Is you flow ___ heavy ___ light ___ medium? Do you get menstrual cramps? ___ Yes ___ No
How long does your period last? _____
Do you have pain or bleeding after sexual intercourse? ___ Yes ___ No
How many times have you been pregnant? _____ How many miscarriages or abortions have you had? _____
How many times have you given birth? _____ How many children do you have? _____
What is your method of birth control? _____
Date of your last pap smear: _____ Have you ever had an abnormal pap? ___ Yes ___ No
Do you get hot flashes? ___ Yes ___ No Do you do self breast examinations? ___ Yes ___ No
When was your last mammogram/breast exam? _____ Was it normal ___ Yes ___ No

Review of Systems

Please check if you have or had any of the following in the past six months:

___ Weight loss/gain
___ Night Sweats
___ Weakness
___ Rashes
___ Itching
___ Dry skin
___ Headaches
___ Injuries
___ Blurred vision
___ Ringing in ears
___ Hearing loss
___ Ear pain
___ Runny nose
___ Nose Bleed
___ Stuffy nose
___ Tooth pain
___ Dentures
___ Mouth sores
___ Sore throat
___ Hoarseness
___ Neck masses
___ Neck stiffness
___ Hair loss/growth

___ Chest pain
___ Racing heart
___ Difficulty breathing
___ Cough
___ Coughing up blood
___ Productive cough
___ Inability to lay flat
___ Breast pain
___ Nipple discharge
___ Mass in breast
___ Loss/increased appetite
___ Nausea
___ Vomiting
___ Diarrhea
___ Constipation
___ Indigestion
___ Vomiting blood
___ Black stools
___ Blood from rectum
___ Changes in bowel habits
___ Cold intolerance
___ Impotence
___ Decreased libido

___ Penile pain
___ Vaginal discharge
___ Irregular bleeding
___ Fatigue
___ Easy bruising
___ Bleeding
___ Pain in joints
___ Pain in muscles
___ Memory problems
___ Tingling in extremities
___ Numbness
___ One-sided weakness
___ Seizures
___ Anxiety
___ Depression
___ Heat intolerance
___ Urinary Tract Infection
(describe) _____
_____
___ Other pain (describe) _____
_____
_____
_____

Received by: _____ Date: _____