MEDICAL HISTORY FORM Date: / / **NURSE**

This information is for use by your physician as part of your confidential medical record

Name _____ Age _____ Birth date _____
Address: _____ Sex [ ] M [ ] F
_____ Home Phone _____
_____ Work Phone _____
EMAIL:_____ Emergency contact _____
Phone _____
Occupation_____
[ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Separated

If married, spouse's name _____
Children's names and ages _____
_____

Allergies to Medications, X-ray dyes, or other substances [ ] No [ ] Yes
(if yes, please list names of medicine and types of reaction)

Past Medical History

Please circle if you have had problems with the following:

1. High blood pressure
2. Diabetes
3. Cancer
4. Heart disease
5. Rheumatic fever
6. Asthma
7. COPD
8. T.B.
9. Allergic Rhinitis
10. Ulcers
11. Hemorrhoids
12. Gall bladder disease
13. Colitis
14. Hepatitis or jaundice
15. Thyroid disease
16. Kidney diseases/stones
17. Degenarative Joint Disease
18. Arthritis
19. Low back problems
20. Skin diseases
21. Blood disorders
22. Venereal diseases
23. Anemia
24. Alcohol /Drug abuse
25. Fibromyalgia
26. Gout
27. Sleep Apnea

Gynecologic and Obstetric History (Female Patients Only)

Age at onset of periods: _____ Frequency: _____ Length of period: _____
Pregnancies: _____ Births: _____ Miscarriages: _____
Prolonged or abnormal bleeding: [ ] No [ ] Yes (please describe) _____
Leakage of urine: [ ] No [ ] Yes (please describe) _____
Pelvic pain: [ ] No [ ] Yes (please describe) _____
Abnormal discharge: [ ] No [ ] Yes (please describe) _____
Abnormal pap smear: [ ] No [ ] Yes (type of treatment) _____
Abnormal mammogram: [ ] No [ ] Yes (type of treatment) _____
Birth Control: [ ] No [ ] Yes (method used) _____

-OVER-

SURGICAL HISTORY:

Please list and supply the dates of:
Surgeries:

Hospitalizations other than for surgery:

FAMILY HISTORY:

Has any member of your family (including parents, grandparents, and siblings) every had the following?

Illness	Which family member?	Approximate age when diagnosed
Cancer (describe type)	_____	_____
Hypertension (high blood pressure)	_____	_____
Heart disease	_____	_____
Diabetes	_____	_____
Strokes	_____	_____
Mental disease (anxiety, depression, etc)	_____	_____
Drug or alcohol addiction	_____	_____
Glaucoma	_____	_____
Bleeding disease	_____	_____
Other:	_____	_____

SOCIAL HISTORY:

Do you smoke?	[ ] No [ ] Yes	If yes, how many packs per day? _____
Do you drink alcoholic beverages?	[ ] No [ ] Yes	If yes, how much per week? _____
Do you drink coffee/tea?	[ ] No [ ] Yes	If yes, how many cups per day? _____
Do you use drugs? (marijuana, cocaine, crack, etc)	[ ] No [ ] Yes	If yes, explain: _____
Have you ever engaged in any activity which has put you at risk of getting AIDS?	[ ] No [ ] Yes	If yes, explain: _____
Do you wish to be tested for AIDS?	[ ] No [ ] Yes	
Have you ever worked with chemicals, paints, asbestos, or other hazardous material?	[ ] No [ ] Yes	If yes, explain: _____
Do you exercise on a regular basis?	[ ] No [ ] Yes	
Are you in a relationship in which you have been physically hurt (slapped, kicked, punched, bruised) by your partner?	[ ] No [ ] Yes	
Do you ever feel afraid of your partner?	[ ] No [ ] Yes [ ] N/A	