Medical History

Date: / /

Name ______________________ Age ____________ Birthdate: ____/____/______
Address ______________________ Sex ☐ M ☐ F
______________________ Home phone ______________________
______________________ Work phone ______________________
Occupation ______________________ Emergency Contact ______________________

☐ 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 name of medicine and type of reaction):

______________ ______________ ______________ ______________
______________ ______________ ______________ ______________
______________ ______________ ______________ ______________
______________ ______________ ______________ ______________

Past Medical History & Review of Systems

Please circle if you have had problems with or are presently complaining of any of the following:

1. High blood pressure
2. Diabetes
3. Cancer
4. Heart disease
5. Chest pain/chest tightness
6. Shortness of breath
7. Swollen ankles
8. Palpitations
9. Lightheadedness
10. Frequent urination
11. Rheumatic fever
12. Asthma
13. Bronchitis
14. Pneumonia
15. Persistent cough
16. T.B.
17. Hay fever
18. Abdominal discomfort
19. Indigestion
20. Nausea
21. Vomiting
22. Constipation
23. Diarrhea
24. Blood in stool
25. Ulcers
26. Change in bowel habits
27. Unexplained weight gain/loss
28. Hemorrhoids
29. Gall bladder disease
30. **Colitis**
31. Hepatitis or jaundice
32. Thyroid disease
33. Heart or neck radiation
34. Headache
35. Kidney diseases
36. Kidney stones
37. Difficulty urinating
38. Arthritis
39. Low back problems
40. Skin diseases
41. Blood disorders
42. Venereal diseases
43. Anxiety
44. Depression
45. Anemia
46. Alcohol abuse
47. Drug abuse
48. Gout
49. ______________
50. ______________

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Gynecologic and Obstetric History

Age at onset of period: ____________ 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): ______________

History of abnormal Pap smear: ☐ No ☐ Yes (Type of treatment): ______________