

DATE \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Name _____	Age _____	Birthdate ____ / ____ / ____
Address _____	Sex: M <input type="checkbox"/> F <input type="checkbox"/>	Home Phone _____
Occupation _____	Work Phone _____	Emergency Contact Phone _____
Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/>		
If Married, Spouse's Name _____		
Children's Names and Ages _____		

<b>Allergies to Medications, X-Ray Dyes, or Other Substances</b>	No <input type="checkbox"/> Yes <input type="checkbox"/>
(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 experiencing any of the following:

1. High Blood Pressure	13. Bronchitis	26. Change in Bowel Habits	38. Arthritis
2. Diabetes	14. Pneumonia	27. Unexplained Weight Gain/Loss	39. Low Back Problems
3. Cancer	15. Persistent Cough	28. Hemorrhoids	40. Skin Diseases
4. Heart Disease	16. T.B.	29. Gall Bladder Disease	41. Blood Disorders
5. Chest Pain/Chest Tightness	17. Hay Fever	30. Colitis	42. Venereal Diseases
6. Shortness of Breath	18. Abdominal Discomfort	31. Hepatitis or Jaundice	43. Anxiety
7. Swollen Ankles	19. Indigestion	32. Thyroid Disease	44. Depression
8. Palpitations	20. Nausea	33. Head or Neck Radiation	45. Anemia
9. Lightheadedness	21. Vomiting	34. Headache	46. Alcohol Abuse
10. Frequent Urination	22. Constipation	35. Kidney Diseases	47. Drug Abuse
11. Rheumatic Fever	23. Diarrhea	36. Kidney Stones	48. Gout
12. Asthma	24. Blood in Stool	37. Difficulty Urinating	49. _____
	25. Ulcers		50. _____

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**GYNECOLOGIC AND OBSTETRIC HISTORY**

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): \_\_\_\_\_

History of abnormal PAP smear: No  Yes  (Type of treatment): \_\_\_\_\_

**Patient Name:** \_\_\_\_\_

**Date:**     /     /

**Please List and Supply the Dates of:**

Operations: \_\_\_\_\_  
                  \_\_\_\_\_

Hospitalizations other than for surgery: \_\_\_\_\_  
                  \_\_\_\_\_

Immunization History – Have you had:                    pneumovax immunization? No  Yes  When?: \_\_\_\_\_  
                  Hepatitis B? No  Yes  When?: \_\_\_\_\_                    flu immunization? No  Yes  When?: \_\_\_\_\_  
                  Other \_\_\_\_\_ ? No  Yes  When?: \_\_\_\_\_                    tetanus immunization? No  Yes  When?: \_\_\_\_\_

When was your last:  
                  pap smear? \_\_\_\_\_                    breast exam? \_\_\_\_\_                    stool check for blood? \_\_\_\_\_  
                  mammogram? \_\_\_\_\_                    cholesterol check? \_\_\_\_\_                    prostate exam? \_\_\_\_\_

**Family History**

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

<b>Illness</b>	<b>Which Family/Members?</b>	<b>Approx. Age When Diagnosed</b>
Cancer (describe type)	_____	_____
Hypertension (High Blood Pressure)	_____	_____
Heart Disease	_____	_____
Diabetes	_____	_____
Strokes	_____	_____
Mental Disease (anxiety, depression, etc.)	_____	_____
Drug or Alcohol Addiction	_____	_____
Glaucoma	_____	_____
Bleeding Diseases	_____	_____
Other: _____	_____	_____

**Medications (Prescriptions, Over-the-Counter, Vitamins, Herbs, etc.)**

<b>Drug Name</b>	<b>Dose</b>	<b>Drug Name</b>	<b>Dose</b>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Prevention**

Do you wear seat belts? No  Yes  If no, why not? \_\_\_\_\_

Do you wear a bike helmet? No  Yes  N/A

Do you exercise regularly? No  Yes  If yes, type, duration and number of times per week? \_\_\_\_\_

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? No  Yes  If yes, how many cups per day? \_\_\_\_\_

Do you drink tea? No  Yes  If yes, how many cups per day? \_\_\_\_\_

If there is a gun in your home do you keep it unloaded and out of children's reach? No  Yes  N/A

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 materials? No  Yes  If yes, explain: \_\_\_\_\_

Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, bruised) by your partner? No  Yes

Do you ever feel afraid of your partner? No  Yes  N/A

Do you have a "living will"? No  Yes

Do you have a donor card? No  Yes

Method of birth control: \_\_\_\_\_