

Patient Medical History Form

The following information is very important to your health. Please take the time to fully and completely fill out this important information.

Patient Name _____ Date of Birth ____/____/____

Phone Number _____ Race _____ Ethnicity _____

Mailing Address _____

Employer _____ Occupation _____

Work Address _____

Emergency Information _____

Primary care physician _____ Phone _____

Other medical providers (ex. dermatologist, cardiologist, internist, surgeon, etc):

	Phone
	Phone
	Phone
	Phone

Preferred local pharmacy _____ mail pharmacy _____

Permission to disclose medical information: ____ yes ____ no If yes, to whom? _____

Preferred mode of notification: ____ mail ____ phone

Past Medical History:

	YES	NO	Please Explain
Anemia			
Arthritis			
Blood Transfusions			
Bowel Disorders			
Breast Disease			
Cancer			
Chicken Pox			
DES Exposure			
Diabetes			
Endometriosis			
Excessive Bleeding			
Gall Bladder			
Headache/Migraine			
Heart Disease			
Hypertension			
Infertility			
Jaundice/Hepatitis			
Kidney Disease			
Psych/Illness/Depression			
Respiratory Disease			
Seizure Disorder			
Skin Disease			
Thyroid Disease			
Urinary Infections			
Varicose Veins/Phlebitis			

List all medication allergies and reactions:

List all food allergies and reactions:

List all environmental/contact allergies:

Family History:

Blood Relative with	Relationship	Age at Onset
Breast Cancer ○ Yes ○ No		
Uterine Cancer ○ Yes ○ No		
Ovarian Cancer ○ Yes ○ No		
High blood pressure ○ Yes ○ No		
Heart Disease ○ Yes ○ No		
Colon Cancer ○ Yes ○ No		
Osteoporosis ○ Yes ○ No		
Diabetes ○ Yes ○ No		
Thyroid Disorder ○ Yes ○ No		

Other family history _____

Social History:

Drug use ____ yes ____ no If yes, please explain _____
 Alcohol use ____ yes ____ no If yes, please explain _____
 Tobacco use ____ yes ____ no If yes, please explain _____
 Caffeine use ____ yes ____ no If yes, please explain _____

Sexuality:

Primary birth control method _____ Age of first menstrual period _____
 Number of sexual partners _____ Age of menopause _____
 Age became sexually active _____

Family:

____ work – occupation _____
 ____ student
 ____ unemployed

Safety:

Domestic violence ____ yes ____ no If yes, please explain _____
 Sexual abuse ____ yes ____ no If yes, please explain _____
 History of rape ____ yes ____ no If yes, please explain _____

List all present medications and dosage:

List all present vitamins and dosage:

Pregnancies:

of pregnancies _____ # of abortions _____
of miscarriages _____ # of live births _____

Any complications with pregnancy? ___yes ___ no If yes, please explain _____

Past Surgical History:

<u>Date</u>	<u>Procedure</u>

Any complications with anesthesia? ___yes ___ no If yes, please explain _____

Past Diagnostic testing (ex. MRI, breast biopsy, EKG):

<u>Date</u>	<u>Procedure</u>

Health maintenance:

<u>Test</u>	<u>Date Last Done</u>
Bone Density	
Colonoscopy	
Flu vaccine	
Mammogram	
Pap Smear	

Immunizations:

<u>Type</u>	<u>Date Done</u>
Flu	
Pneumonia	
Gardasil	
Hep B	
Hep A/B (Twinrix)	
Hep A	