

New 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 _____ Age _____ Birth Date _____ Today's Date _____

List all present medications/supplements and dosage:

List all medication allergies and reactions:

Family History

Family Member	Age	Current Health Excellent Good Poor	Age at Death	Cause of Death		Blood Relative with	Relationship	Age at Onset
Father						Breast Cancer <input type="radio"/> Yes <input type="radio"/> No		
Mother						Ovarian Cancer <input type="radio"/> Yes <input type="radio"/> No		
Brother/Sister						Uterine Cancer <input type="radio"/> Yes <input type="radio"/> No		
2						Colon Cancer <input type="radio"/> Yes <input type="radio"/> No		
3						Diabetes <input type="radio"/> Yes <input type="radio"/> No		
4						Heart Trouble <input type="radio"/> Yes <input type="radio"/> No		
5						High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No		
Grandparents						Epilepsy <input type="radio"/> Yes <input type="radio"/> No		
Son/Daughter						Stroke <input type="radio"/> Yes <input type="radio"/> No		
2						Osteoporosis <input type="radio"/> Yes <input type="radio"/> No		
3						Note: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.		

Other family history _____

Personal History: Do you have now or have you ever had any of the following?

	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			
Hiatal Hernia/Peptic Ulcer			
Hypertension			
Infertility			
Jaundice/Hepatitis			
Kidney Disease			
Psych/Illness/Depression			
Respiratory Disease			
Seizure Disorder			
Skin Disease			
Thyroid Disease			
Urinary Infections			
Varicose Veins/Phlebitis			

Past Surgical History:

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

Illness History (Other than Surgical Procedures):

<u>Date</u>	<u>Illness</u>

Test (Give Date Last Done):

<u>Test</u>	<u>Year Performed</u>	<u>Not Sure</u>	<u>Never Done</u>	<u>Results</u>
Bone Density				
Breast Exam				
Cholesterol				
Colonoscopy				
Mammogram				
Pap Smear				
Rectal Exam				
Rubella				
Sigmoidoscopy				
Tetanus (DPT)				
Thyroid Profile				
Triglycerides				
Other _____				

Menstrual Periods:

Age of Onset _____ Problems with Breasts _____

Date of Last Period _____ Unusual Vaginal Discharge _____

Periods: Regular ___ Irregular ___ Difficulty with Periods _____

Pregnancies:

of Children Born Alive _____ # of Cesarean Sections _____

of Premature Births _____ # of Stillborns _____

of Miscarriages _____ # of Abortions _____

Describe any complications: _____

Your Personal Habits:

Do you or have you ever:	<u>YES</u>	<u>NO</u>	<u>Please Explain</u>
Exercise regularly (3 to 4 times per week)?			
Use illegal drugs?			
Use alcohol? If so, how much?			
Were you ever a heavy drinker?			
Smoke cigarettes? If so, how much?			
If ever, when did you stop?			
Have an eating disorder?			
Anorexia Bulimia			
Have you ever been physically abused?			
Are you currently being physically abused?			
Do you feel safe in your home?			
Have sex with: men ___ women ___ both _____			
Have any concerns?			

My signature indicates that the above information is true and correct to the best of my knowledge.

Patient Signature _____ Date _____

Medical History Reviewed by _____ Date _____