

## PATIENT MEDICAL HISTORY

PATIENT NAME: \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_ Which Physician are you seeing today? \_\_\_\_\_

RACE: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_ REFERRED BY: \_\_\_\_\_

REASON FOR TODAY'S VISIT: \_\_\_\_\_

DATE OF LAST PAP SMEAR: \_\_\_\_\_ NORMAL / ABNORMAL Comment: \_\_\_\_\_

DATE OF LAST MAMMOGRAM: \_\_\_\_\_ NORMAL / ABNORMAL Comment: \_\_\_\_\_

ARE YOU ALLERGIC TO MEDICATIONS:  NO  YES PLEASE LIST: \_\_\_\_\_

ARE YOU CURRENTLY TAKING MEDICATIONS:  NO  YES PLEASE LIST: \_\_\_\_\_

DO YOU SMOKE TOBACCO PRODUCTS?  NO  YES HOW LONG? \_\_\_\_\_ YRS HOW MANY PER DAY? \_\_\_\_\_

DO YOU DRINK CAFFEINATED BEVERAGES?  NO  YES HOW MANY CUPS/CANS PER DAY? \_\_\_\_\_

DO YOU DRINK ALCOHOLIC BEVERAGES?  NO  YES CIRCLE ONE: RARELY / SOCIALLY / WEEKLY / DAILY

ARE YOU SEXUALLY ACTIVE?  NO  YES MORE THAN ONE PARTNER?  NO  YES

DO YOU HAVE MENSTRUAL CYCLES?  NO  YES IF YES, DATE LAST MENSTRUAL PERIOD BEGAN? \_\_\_\_\_

HEIGHT: \_\_\_\_\_

ARE YOU CURRENTLY USING BIRTH CONTROL?  NO  YES

- BIRTH CONTROL PILLS
- CONDOMS
- DIAPHRAGM
- I.U.D.
- NORPLANT
- SPERMICIDES
- TUBALIGATION STERILIZATION
- VASECTOMY
- OTHER: \_\_\_\_\_

DO YOU HAVE AN ADVANCED DIRECTIVE?  YES  NO

(This is a person's desires about withholding and/or withdrawing medical treatment in the event he or she suffers from an incurable and terminal condition.)

## OBSTETRICAL HISTORY

MO./YEAR	GEST.AGE	VAGINAL OR CESAREAN	HOURS IN LABOR	BABY'S SEX	BABY'S WEIGHT	BABY'S FIRST NAME	REMARKS:

NUMBER OF CHILDREN NOW LIVING? \_\_\_ NUMBER OF MISCARRIAGES/STILLBIRTHS? \_\_\_ NUMBER OF ABORTIONS? \_\_\_

### HOSPITALIZATIONS & SURGICAL HISTORY

MONTH / YEAR	SURGERY / ILLNESS	SURGEON OR ADMITTING PHYSICIAN	REMARKS

### PERSONAL AND FAMILY MEDICAL HISTORY

PLEASE MARK ALL THAT APPLY TO YOU OR YOUR FAMILY:

**PT. FAMILY**

- A.I.D.S.
- ALCOHOLISM
- ANEMIA
- ANOREXIA
- ARTHRITIS
- ASTHMA
- BLEEDING DISORDERS
- BOWEL DISORDERS
- BREAST DISEASE
- BULIMIA
- CANCER
- CATARACTS
- CHEMICAL DEPEND.
- DIABETES
- EPILEPSY/SEIZURES
- GALL BLADDER DIS.
- GLAUCOMA
- GENETIC DISORDERS
- GONORRHEA

**PT. FAMILY**

- HEART DISEASE
- HEPATITIS
- HERNIA
- HERPES
- HIGH CHOLESTEROL
- HIV POSITIVE
- HYPERTENSION
- KIDNEY DISEASE
- LIVER DISEASE
- LUNG DISEASE
- MIGRAINE HEADACHE
- MITRAL VALVE PROLAPSE
- MONONUCLEOSIS
- MULTIPLE SCLEROSIS
- PACEMAKER
- PHLEBITIS
- PNEUMONIA
- PSYCHIATRIC CARE
- RHEUMATIC FEVER

**PT. FAMILY**

- SICKLE CELL
- SKIN DISEASE
- STROKE
- THYROID PROBLEMS
- TUBERCULOSIS
- ULCERS
- URINARY INCONTINENCE
- URINARY INFECTION
- URINARY ABNORMALITIES
- VENEREAL DISEASE
- WEIGHT GAIN / LOSS
- OTHER: \_\_\_\_\_
- OTHER: \_\_\_\_\_
- OTHER: \_\_\_\_\_

COMMENTS: \_\_\_\_\_  
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