Medical History

Name ______________________ Age ____________ Date ______________

ALLERGIES	FAMILY HISTORY				
		Father	Mother	Siblings	Children
	Heart Disease				
	High Blood Pressure				
	Stroke				
Family History	Cancer				
Father: Living or Deceased Age	Glaucoma				
Mother: Living or Deceased Age	Diabetes				
Siblings: Living or Deceased Age	Epilepsy/ Seizures				
	Bleeding Disorder				
	Kidney Disease				
	Thyroid Disease				
	Mental Illness				
	Arthritis				

Hospitalization or Surgery

Reason	Date	Reason	Date

Past Medical History

			Date of Last Immunization
☐ Allergies	☐ Gallbladder Disease	☐ Nervousness	
☐ Anemia	☐ Gout	☐ Pneumonia	☐ Flu Vaccine
☐ Arthritis	☐ Headache/Migraines	☐ Prostate Disease	☐ Tetanus
☐ Bowel Irregularity	☐ Heart Murmur	☐ Rheumatic Fever	☐ Pneumonia
☐ Bronchitis	☐ Heart Palpitations	☐ Seizure Disorder	☐ MMR
☐ Cancer	☐ Hepatitis	☐ Sexual/Menstrual Dysfunction	☐ PPD
☐ Chest Pain	☐ High Cholesterol	☐ Shortness of breath	☐ Other
☐ Depression	☐ High Triglycerides	☐ Ulcer	
☐ Diabetes	☐ Hypertension	☐ Other	

Habits/Risk Factors

Smoke Yes No Ever Smoked Yes No

Packs Daily? ___________ How Long? _______________

Alcohol Yes No Type? ____________________

Street Drugs? Yes No Type? ____________________

Contact with blood/bodily fluids at work? Yes No

Coffee: Cups Daily? __________________ Other Caffeine? ___________ No

Diet: _______________ Fat Intake _________________ Salt Intake

Exercise? Yes No Type? _____________ Amount? ____________

Sleep Patterns? ______________________________________

Advance Directive

Advance Directive? Yes No

(*If yes, please provide a copy*)

Women Only

Menstruation: First Age: _________________

Flow is: Light Moderate Heavy

Days between Period: ____________________

Days Period Lasts: ____________________

Date of last Period: ____________________

Pregnant? Yes No Planning Yes

Total # of pregnancies: __________________

Full term? Yes No

Number of living children: _________________

Age of youngest? _______________________

Type of Birth Control? _____________________

Gynecologist name _____________________

Date of last Pap Smear? __________________

Date of last Breast Exam? ________________

Date of last Mammogram? ________________