**MEDICAL HISTORY FORM TEMPLATE**

# General Information

Name Address Contact phone numbers Birth date

## Family Physician and/or Primary Health Care Provider:

Doctor/Other Address

Phone City

A copy of your visit/labs will be sent to your physician or primary health care provider.

# Past Medical History

## Check those questions to which you answer yes (leave the others blank) & comment below. Have you ever had or do you have any of the following health problems?

 Substance Abuse:

* Alcohol
* Marijuana
* Other drugs

 Bleeding tendency

 Breast disease

 Cancer

* Breast
* Uterine
* Other

 Psychiatry o Depression o Anxiety

* Bipolar
* Eating disorder

 Diabetes

 High cholesterol

 Cardiac

* Heart murmur
* Heart attack
* High blood pressure

 Hepatitis

 Glaucoma

 Dental disease

 Neuro

* Migraine
* Stroke
* Seizure
* Other

 GI

* Jaundice
* Liver disease
* Gallbladder disease
* Gastritis/Ulcer disease
* Acid reflux
* Hemorrhoids
* Other

 Kidney

* Kidney infection
* Bladder infection
* Kidney stones

 Thyroid disorder

 Varicose veins

 Seizure disorder

 Lung

* Sleep apnea
* Asthma
* Chronic Obstructive Pulmonary Disease
* Tuberculosis
* Seasonal allergies
* Other

 Environmental allergies

 Blood clots

 Serious trauma

 Sexually transmitted infection

 Other

## Comments:

**SYMPTOMS**

**Are you currently having or have you recently had any of the following symptoms? Check those questions to which you answer yes (leave the others blank).**

 Fevers

 Night sweats

 Unexplained weight loss/gain

 Fatigue

 Headaches

 Vision problems

 Hearing problems

 Dizziness

 Ringing in ears

 Eye pain

 Ear pain

 Nosebleeds

 Sore throat

 Difficulty swallowing

 Hoarse voice

 Persistent cough

 Coughing up blood

 Chest pain

 Palpitations/irregular heartbeat

 Swelling of extremities

 Shortness of breath

 Lightheadedness

 Change in appetite

 Abdominal pain

* Nausea
* Vomiting
* Diarrhea

 Rectal pain

* Change in bowel habits
* Blood in stool
* Black stool

 Muscle, bone or joint pain

 Leg cramps

 Skin color changes

 Persistent bruising

 Inability to sleep flat

 Change in size/color of mole

 Numbness of extremities

 Muscle weakness

 Tremor

 Urinary symptoms

* Blood in urine
* More frequent urination
* Incontinence/loss of urine
* Pain

 Sexual dysfunction

 Mood changes

 Difficulty sleeping

## Comments:

### SURGERIES:

Type of surgery and specific date or your age at surgery:

### HOSPITALIZATIONS:

List hospitalizations, including dates of and reasons for hospitalization:

### MEDICATIONS:

List any prescription medications (with dosage and frequency of use) you are now taking:

List any self-prescribed medications, dietary supplements, or vitamins (with dosage and frequency of use)

you are now taking:

### ALLERGIES:

List any drug or medical materials (latex) allergies and reaction:

**Family History**

## Indicate illnesses in blood relative (i.e. parents, grandparents, siblings) - Check those questions to which you answer yes (leave the others blank).

 Substance Abuse:

* Alcohol
* Marijuana
* Drugs

 Anemia

 Bleeding or clotting abnormality

 Breast disease

 Cancer

* Prostate
* Skin
* Colon
* Lung
* Breast cancer
* Other

 Diabetes

 Heart disease

 High cholesterol

 High blood pressure

 Mental illness

 Depression

 Suicide

* Sibling
* Parents
* Grandparents

 Migraines/headaches

 Stroke

 Thyroid disorder

 Arthritis

* Rheumatoid
* Osteoarthritis

 Connective tissue disorder

* Lupus
* Scleroderma

## Health and Lifestyle

Do you smoke?

 Yes  No

If you smoke, how many per day? Age started

Are you concerned about your own or someone else’s alcohol abuse? Yes No Have you ever felt you should cut down on your drinking? Yes No Have people annoyed you by criticizing your drinking? Yes No

Have you ever felt bad or guilty about your drinking? Yes No

Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover? Yes  No

Do you often having the feeling of being overwhelmed or depressed?  Yes No Do you exercise? Yes No

If yes, type of exercise:

If yes, frequency of exercise: Do you use a seatbelt at least 90% of the time? Yes No

### Immunization Update: Check box if yes and put date received.

Tetanus:  Date:

Measle, Mumps, Rubella:  Date: Flu Shot:  Date: \_\_\_\_\_\_\_\_\_\_\_

Varicella (chicken pox) vaccine:  Date: \_\_\_\_\_\_\_\_\_\_\_ Pneumovax (pneumonia) vaccine:  Date: \_\_\_\_\_\_\_\_\_\_\_ Zoster (shingles) vaccine:  Date: \_\_\_\_\_\_\_\_\_\_\_

## Sexual History

Have you ever been sexually active? Yes No Are you currently sexually active? Yes No

### Complete the following questions if you are sexually active.

Are you currently having sexual relations with one partner or multiple partners?

One Multiple

Number of partners in last year:

Are you in a monogamous relationship? Yes No Are/Is your sexual partner(s): Men Women Both

Do you and your partner use contraceptive and/or protective methods? Yes No

Have you ever had a sexually transmitted illness (STI) (i.e. HPV, Herpes, Chlamydia, Gonorrhea or other)?

Yes No

List STI: Treated: Yes No

## Gynecologic History

Do you have a period every month? Yes No Number of days of flow:

Menstrual cramps: Mild Moderate Severe None

Date of last PAP smear: Last PAP smear result:

Have you ever had an abnormal PAP smears? Yes No

If yes, explain clinical history (including test location, date, what was done) for any abnormal PAP smear:

Number of pregnancies:

Are you presently trying to become pregnant or will be trying soon? Yes No

Gynecologic symptoms: **Check those questions to which you answer yes (leave the others blank).**

 Abnormal menstrual bleeding

 Missed periods

 Night sweats

 Hot flashes

 Vaginal dryness

Have you ever had a mammogram? Yes No

If applicable, indicate the date and result of your last mammogram:

 History of prescription hormone use

 Mood changes associated with period

 Insomnia