

Personal Medical History

Surgical History– please list all surgeries you have had and approximate dates.

A _____ B _____

C _____ D _____

E _____ F _____

Hospitalizations: A _____ B _____

C _____ D _____

E _____ F _____

Please list current medications you are taking: 1 _____ 2 _____

3 _____ 4 _____ 5 _____ 6 _____

7 _____ 8 _____ 9 _____ 10 _____

Please list any allergies to medications: _____

Did you have any unusual childhood illnesses? _____
(rheumatic fever or seizures)

Past Medical History

Have you had any past history of medical problems in the following areas? If so, please describe.

1. Eye or visual problems? _____

2. Ear, nose or throat problems? _____

3. Heart problems or high blood pressure? _____

4. Have you ever had a blood transfusion? _____

5. Liver or Gallbladder disease (hepatitis, jaundice, gallstones)? _____

6. Stomach disorders (ulcers, gastritis, hiatal hernia)? _____

7. Intestinal Disorders (colitis, spastic colon, polyps)? _____

8. Recurrent urinary tract infections? _____

9. Kidney disease? _____

10. Anemia or blood disorders? _____

11. Bone or joint disease (arthritis or osteoporosis)? _____

12. Neurological problems(migraines)? _____

13. Mental disorders (depression, anxiety, attacks, nervous breakdown)? _____

Family History-please list any family members with the following illnesses (parents, siblings, grandparents, aunts, uncles)

A. Cancers & type: 1 _____ 2 _____

3 _____ 4 _____

5 _____ 6 _____

B. Bleeding/ Clotting: 1. _____ 2 _____

3 _____ 4 _____

5 _____ 6 _____

C. Autoimmune: 1 _____ 2 _____

3 _____ 4 _____

D. Genetic Disease & type 1 _____ 2 _____

3 _____ 4 _____

E. Heart Disease:1 _____ 2 _____

3 _____ 4 _____

Social History

Cigarette smoking: yes / no Amount _____ Alcohol use: yes / no Frequency _____

Drug use (past or present) _____

Review of Systems- are you currently having any of the following problems?

_____ chest pain, shortness of breath, irregular heart rate

_____ coughing up of sputum, blood or wheezing

_____ breast pain, nipple discharge or bleeding

_____ abdominal pain

_____ black, tarry stools, blood or mucus in stools

_____ persistent diarrhea or constipation

_____ pain or swelling in joints

_____ burning with urination, blood in urine, or unusual urinary frequency

_____ involuntary loss of urine

_____ vaginal discharge, burning or itching

_____ painful intercourse

_____ pelvic pain

Questions or Concerns _____
