Medical History Form

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Medical History Form

Today's Date: _______________
Name: ____ Date of Birth: _________________
Address: ____
____
Phone Number: ________________ Cell: ______________ Email: _____________________
Primary Care Physician's Name: _______________________ Phone Number: ____________
Reason for your visit today:

Menstrual History

Last Menstrual Period: ______________ Describe your periods: ____________________________
How many pregnancies?____ Vaginal Del.:____ Cesarean Del.:___ Miscarriage(s):____ Abortion(s):____
Date of Last Pap Smear:____ Mammogram:____ Bone Scan:____ Colonoscopy:____ Sigmoidoscopy:____

Medical/Surgical History

Have you or any member of your family had:

Condition		Condition	
Seizures	N ___ Y ___	Tuberculosis	N ___ Y ___
Headaches	N ___ Y ___	Herpes	N ___ Y ___
Chest Pain	N ___ Y ___	Hepatitis	N ___ Y ___
Heart Trouble	N ___ Y ___	HIV	N ___ Y ___
Diabetes	N ___ Y ___	HPV	N ___ Y ___
Rheumatic Fever	N ___ Y ___	Chickenpox	N ___ Y ___
Pneumonia	N ___ Y ___	Bleeding Tendency	N ___ Y ___
Asthma	N ___ Y ___	Breast Cancer	N ___ Y ___
Kidney Disease	N ___ Y ___	Ovarian Cancer	N ___ Y ___
Liver Disease	N ___ Y ___	Colon Cancer	N ___ Y ___
Clotting Disorder	N ___ Y ___	Blood Transfusion	N ___ Y ___
Thyroid Disease	N ___ Y ___	Drug Allergies	N ___ Y ___
Autoimmune Disorder	N ___ Y ___	Substance Abuse	N ___ Y ___
Mitral Valve Prolapse	N ___ Y ___	Depression	N ___ Y ___

Please explain any "Yes" responses here:

Patient Social History

Marital Status: ____________Husband's Name: _____________Occupation: _______________
Alcohol Use: N____Y____ If yes, how much/how often? ______________________________
Tobacco Use: N____Y____ If yes, how much/how often? ______________________________
Drug Use: N____Y____ If yes, how much/how often? ______________________________
Your Occupation: ____________________________ How long? _______________________
Is there anything else you think we should know that may be affecting your health and/or well being?