MEDICAL HISTORY

DATE: ____________________________

NAME: ____ DATE OF BIRTH: _________________ SEX: ________
Last First Middle

ADDRESS: ____

HOME PHONE: ____________________ WORK PHONE: _________________ NATIONALITY: ____________________________

NAME AND RELATIONSHIP OF NEXT OF KIN: _________________________________ PHONE: ______________________

ADDRESS: ____

SOCIAL HISTORY

MARITAL STATUS: SINGLE ________ MARRIED ________ SEPARATED ______ DIVORCED ________ WIDOWED ______

DO YOU USE TOBACCO? YES ☐ NO ☐ HOW MUCH? _____________________ FORM OF USE: ____________________

DO YOU USE ALCOHOL? YES ☐ NO ☐ HOW MUCH? _____________________ FORM OF USE: ____________________

DO YOU EXERCISE? YES ☐ NO ☐ HOW OFTEN? ____________________ WHAT KIND? ______________________

ARE YOU UNDER ANY UNUSUAL STRESS? YES ☐ NO ☐ EXPLAIN: _______________________________________

OCCUPATION: ____ AGES OF CHILDREN: ______________________

PAST MEDICAL HISTORY

LIST ALL SURGERIES AND THE YEAR PERFORMED: ____

____

LIST ANY OTHER HOSPITALIZATIONS AND THE YEAR: ____

____

LIST ANY OTHER SERIOUS ILLNESSES OR ACCIDENTS: ____

____

LIST ANY ALLERGIES TO MEDICATIONS: ____

LIST ANY OTHER ALLERGIES: ____

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:____

____

HAVE YOU EVER HAD X-RAY TREATMENTS TO YOUR HEAD OR NECK FOR ACNE OR TONSILLITIS? YES ☐ NO ☐

FAMILY HISTORY

PLEASE INDICATE IF ANY OF YOUR BLOOD RELATIVES HAVE HAD ANY OF THE FOLLOWING:

CHECK EACH ITEM	YES	NO	RELATIONSHIP	CHECK EACH ITEM	YES	NO	RELATIONSHIP
CANCER				STROKE			
DIABETES				GLAUCOMA			
HIGH BLOOD PRESSURE				EPILEPSY/CONVULSIONS			
HEART DISEASE				NERVOUS/MENTAL DISORDER			
LUNG DISEASE				ALCOHOL/SUBSTANCE ABUSE			

HOW MANY LIVING BROTHERS: ____________ SISTERS: ____________ PARENTS: ____________

LIST RELATIONSHIP, AGE AND CAUSE OF DEATH FOR ANY DECEASED PARENTS, BROTHERS, OR SISTERS:

____

____

IMMUNIZATIONS

TETANUS: YES ☐ NO ☐ YEAR ___________ PNEUMOCOCCAL VACCINE: YES ☐ NO ☐ YEAR ___________

WOMEN ANSWER THE FOLLOWING:

DATE: ________________________

NAME: ____ DATE OF BIRTH: ____________________
Last First Middle

AGE AT ONSET OF PERIODS: ________________________ OR AGE OF MENOPAUSE: ________________________

PERIODS OCCUR EVERY ____DAYS. FLOW LASTS FOR _____DAYS. PAIN/CRAMPS: YES ☐ NO ☐ SOMETIMES ☐

FLOW IS: _________ LIGHT ________ MODERATE _________ HEAVY

BLEEDING BETWEEN PERIODS: YES ☐ NO ☐ HOW MUCH? ________________ HOW OFTEN?________________

DATE OF LAST MENSTRUAL PERIOD: ____________________ IF NOT NORMAL, DESCRIBE: ____________________

DATE OF LAST PAP SMEAR: ____________________________ IF NOT NORMAL, DESCRIBE: ____________________

DATE OF LAST MAMMOGRAM: ___________ I DO BREAST SELF-EXAMS: YES ☐ NO ☐ HOW OFTEN? ________

NUMBER OF PREGNANCIES: ________ NUMBER OF LIVING CHILDREN: ________

NUMBER OF ABORTIONS (ELECTIVE OR SPONTANEOUS): ________

CONTRACEPTIVES USED: _____NONE _____PILLS _____ IUD _____DIAPHRAGM OTHER: _________________