### MEDICAL HISTORY

**Patient ID# __________________________  Date:  /  /**

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<tr>
<th>Name</th>
<th>Birth date</th>
<th>Age</th>
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Reason for visit/concerns you want to discuss?  
__________________________________________________________________________________________

Allergies to Medications, X-Ray Dyes, or Other Substances.  

- No  
- Yes  

(If yes, please list name of medicine and type of reaction):  
__________________________________________________________________________________________

### PAST MEDICAL HISTORY

- Alcohol Problems
- Anemia
- Arthritis:  Osteo / Rheumatoid
- Asthma
- Blood disorders: Type ____________________________
- Cancer: Type: ____________________________
- h/o Chicken Pox or Shingles
- Chron’s Ds
- Colon or bowel disease
- Depression / Anxiety
- Diabetes: Insulin / Non-Insulin
- Drug Problems
- GERD
- Heart Disease
- Hepatitis cirrhosis or jaundice
- High Blood Pressure
- HIV or AIDS
- Hypercholesterolemia
- IBS
- Kidney disease or kidney stones
- Mitral valve prolapse or heart murmur
- Osteoporosis / Osteopenia
- Seizure disorder/epilepsy
- Skin disease: Type ____________________________
- TB/emphysema/lung disease
- Thyroid disease: Hypo / Hyper
- Ulcerative Colitis
- Ulcers
- Other ____________________________

### MEDICATIONS

(Prescriptions, Over-the-Counter, Vitamins, Herbs)

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### SURGICAL HISTORY AND HOSPITALIZATIONS

(List all hospitalizations and operations – include dates)

- Operations & Dates
- Operations & Dates
- Operations & Dates
- Operations & Dates
- Operations & Dates
- Operations & Dates

Have you ever had a blood transfusion?  

- No  
- Yes  

This information is for use by your physician as part of your confidential medical records. Please continue on back.

MH-01.25.2013
Marital Status: ___________________  Occupation: ______________________________________

# Current Sexual Partners: _________  # Lifetime Sexual Partners: __________

Age of 1st Intercourse: __________________

Do you smoke?  No ☐  Yes ☐  If yes, how many packs per day: ___  When did you start? ___  If you quit, when? ___

Do you drink alcohol?  No ☐  Yes ☐  If yes, how much per week: ___________________________________________

Do you use drugs?  No ☐  Yes ☐  If yes, explain: ________________________________

Are you in a relationship in which you have been physically hurt by your partner?  No ☐  Yes ☐

Have you ever engaged in any activity which has put you at risk for AIDS?  No ☐  Yes ☐

Do you want to be tested for AIDS?  Yes ☐  No ☐

Do you want to be tested for sexually transmitted diseases?  Yes ☐  No ☐

Have you vomited/used laxatives as a way to control your weight?  Yes ☐  No ☐

Age of periods: _____  Frequency: _____  Length of period: _____  Last period: _____  Age of Menopause: _____

- Prolonged or abnormal bleeding:  Yes ☐  No ☐  If yes, please describe: ___________________________________________
- Leakage of urine:  Yes ☐  No ☐  If yes, please describe: ___________________________________________
- Pelvic pain:  Yes ☐  No ☐  If yes, please describe: ___________________________________________
- Abnormal discharge:  Yes ☐  No ☐  If yes, please describe: ___________________________________________
- History of abnormal Pap smear:  Yes ☐  No ☐  If yes, please describe: ___________________________________________
- History of sexually transmitted diseases (i.e. chlamydia, warts, human papilloma virus, gonorrhea, herpes):  Yes ☐  No ☐  If yes, please describe: ___________________________________________

- When was your last pap smear? __________  When was your last bone density? __________
- When was your last mammogram? __________  When was your last colonoscopy? __________

- Are you currently sexually active?  Yes ☐  No ☐  Place/Hospital of birth: ___________________________________________
- Birth control method?  N/A ☐  Yes ☐  No ☐  If yes, please describe: ___________________________________________

# of pregnancies: __________  # of full term deliveries: __________  # weeks at time of delivery: __________
Place/Hospital of birth: __________________________________________  year of birth: __________  gender: ______

# of vaginal deliveries: __________  # C-sections: __________  Complications (if any): ___________________________________________

# of preterm deliveries: __________  # weeks at time of delivery: __________
Place/Hospital of birth: __________________________________________  year of birth: __________  gender: ______

# of vaginal deliveries: __________  # C-sections: __________  Complications (if any): __________________________________________

Treatments/Hospitalizations: ___________________________________________

# of miscarriages: __________  # weeks at time of miscarriage: __________  # of terminations __________

Autimmune Disorder ☐  Bleeding Disorders ☐
CANCER ☐  Breast ☐  Colon ☐  Lung ☐  Ovarian ☐  Uterine ☐  Other: __________________________

Diabetes ☐  Heart Disease ☐  High Blood Pressure ☐
Hypercholesterolemia ☐  Osteoporosis ☐  Stroke ☐  Thyroid Ds ☐

OTHER: __________________________________________

Signature: ___________________  Date: ___________________