MEDICAL HISTORY

PLEASE PRINT — THIS INFORMATION BECOMES PART OF YOUR CONFIDENTIAL MEDICAL RECORD — PLEASE PRINT

Name

Last First MI

Age _____ Today's Date _____

Date of Birth _____

Type of Work _____

Marital Status _____ Religion _____

Education (years completed)

Grade ____ High ____ Vocational _____ College ____

Previous Physician _____

PAST HISTORY (GIVE NAMES AND DATES)

PREVIOUS SURGERY FRACTURES INJURIES	
PREVIOUS HOSPITALIZATIONS MAJOR ILLNESS CHRONIC CONDITIONS	

FAMILY HISTORY	AGE IF LIVING	AGE AT DEATH	PRESENT CONDITION OR CAUSE OF DEATH
FATHER			
MOTHER			
BROTHERS NUMBER _____			
SISTERS NUMBER _____			
CHILDREN NUMBER _____			

CHECK IF ANY RELATIVES HAVE HAD

- ☐ DIABETES
- ☐ HEART TROUBLE
- ☐ HEART ATTACK
- ☐ HIGH BLOOD PRESSURE
- ☐ STROKE
- ☐ CANCER
- ☐ TUBERCULOSIS
- ☐ ULCERS
- ☐ ARTHRITIS
- ☐ OBESITY (OVER WEIGHT)
- ☐ EMOTIONAL PROBLEMS
- ☐ THYROID TROUBLE
- ☐ ALCOHOL
- OTHER: _____

NUMBER LIVING IN YOUR HOUSEHOLD : _____

SMOKING

PACKS PER DAY _____

NO. OF YEARS _____

YEARS STOPPED _____

PIPE ☐ CIGAR ☐ CHEW ☐

ALCOHOL

NEVER ☐ OCCASIONAL ☐

MODERATE ☐ HEAVY ☐

ALCOHOL PROBLEM

YES ☐ NO ☐

COFFEE

CUPS PER DAY _____

EXERCISE

TYPE _____

FREQUENCY

PRESENT WEIGHT _____ LBS

USUAL WEIGHT _____ LBS

WEIGHT AT AGE 20 _____ LBS

WEIGHT CHANGE LAST YEAR

GAINED ____LBS LOST ____LBS

HEIGHT _____

Medications (Prescription, Over-the-Counter, Vitamins, Herbs, etc.)

DRUG NAME	DOSE	DRUG NAME	DOSE

SPECIFY ANY DRUG REACTION OR ALLERGY: _____

PLEASE COMPLETE OTHER SIDE

Past Medical History & Review of Systems

Please check if you have had problems with or are presently complaining of any of the following:

1. ☐ High Blood Pressure
2. ☐ Diabetes
3. ☐ Cancer
4. ☐ Heart Disease
5. ☐ Chest Pain/Chest Tightness
6. ☐ Shortness of Breath
7. ☐ Swollen Ankles
8. ☐ Palpitations
9. ☐ Light-headedness
10. ☐ Frequent Urination
11. ☐ Rheumatic Fever
12. ☐ Asthma
13. ☐ Bronchitis
14. ☐ Pneumonia
15. ☐ Persistent Cough
16. ☐ T.B.
17. ☐ Hay Fever
18. ☐ Abdominal Discomfort
19. ☐ Indigestion
20. ☐ Nausea
21. ☐ Vomiting
22. ☐ Constipation
23. ☐ Diarrhea
24. ☐ Blood in Stool
25. ☐ Ulcers
26. ☐ Change in Bowel Habits
27. ☐ Unexplained Weight Loss/Gain
28. ☐ Hemorrhoids
29. ☐ Gall Bladder Disease
30. ☐ Colitis
31. ☐ Hepatitis or Jaundice
32. ☐ Thyroid Disease
33. ☐ Head or Neck Radiation
34. ☐ Headache
35. ☐ Kidney Disease
36. ☐ Kidney Stones
37. ☐ Difficulty Urinating
38. ☐ Arthritis
39. ☐ Low Back Problems
40. ☐ Skin Disease
41. ☐ Blood Disorders
42. ☐ Venereal Disease
43. ☐ Anxiety
44. ☐ Depression
45. ☐ Anemia
46. ☐ Alcohol Abuse
47. ☐ Drug Abuse
48. ☐ Gout
49. ☐ _____
50. ☐ _____

OTHER: _____

Prevention

Do you wear seatbelts?	☐ No	☐ Yes	If No, Why Not? _____
Do you wear a bike helmet?	☐ No	☐ Yes	N/A
If there is a gun in your home, is it out of children's reach & unloaded?	☐ No	☐ Yes	N/A
Do you use drugs? (Marijuana, Cocaine, Crack, etc.)	☐ No	☐ Yes	If yes, explain: _____
Have you ever engaged in any activity which has put you at risk of getting AIDS?	☐ No	☐ Yes	If yes, explain: _____
Do you wish to be tested for AIDS?	☐ No	☐ Yes	
Have you ever worked with chemicals, paints, asbestos, or other hazardous materials?	☐ No	☐ Yes	If yes, explain: _____
Are you in a relationship in which you have been physically hurt (E.G., slapped, kicked, punched, buised) by your partner?	☐ No	☐ Yes	
Do you feel afraid of your partner?	☐ No	☐ Yes	
Do you have a living will?	☐ No	☐ Yes	
Do you have a donor card?	☐ No	☐ Yes	

FOR WOMEN ONLY

Date Last Menstruated? _____

Period every _____ Days.

Any Menstrual Problems? Yes ☐ No ☐

Heavy Periods _____

Irregular Periods _____

Infrequent Periods _____

Painful Periods _____

Spotting _____

Discharge _____

Number of Pregnancies _____

Number of Miscarriages _____

Birth Control Method (if any) _____

Date of Last Pap Smear _____

Check if you have had:

- ☐ D&C
- ☐ Hysterectomy
- ☐ Difficulty with pregnancy
- ☐ …With labor
- ☐ …With delivery
- ☐ Toxemia
- ☐ Cesarean sec.

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