Your name _____

Emergency Contact (someone not living with you)

Name _____
Address _____
_____
Phone: Home _____ Work _____
Relationship _____

Patient's Medical History

Surgery _____

Pregnancies _____

Medical Illnesses and Injuries _____

_____

Allergies _____

Review of Systems: Please circle if you are having or have had any of the following.

1. High Blood Pressure
2. Chest Pain
3. Shortness of Breath
4. Swollen Ankles
5. Dizziness
6. Joint Pain
7. Muscle Pain
8. Chronic Cough
9. Palpitations
10. Indigestion
11. Abdominal Pain
12. Nausea / Vomiting
13. Diarrhea
14. Bloody Stools
15. Heartburn
16. Cramps
17. Weight Change
18. Bowel Change
19. Head / Neck Pain
20. Painful Urination
21. Urine Leakage
22. Back Pain
23. Rash
24. Anxiety / Depression
25. Weakness / Fatigue
26. Visual Difficulties

Explanation: _____
_____
_____
_____
_____

All of this history is fully confidential. Please feel free to discuss any health or social problems you might be having. Please make another appointment if necessary to discuss personal matters in detail.

Your Name _____

Menstrual History

Age at onset _____ Regular _____ Frequency _____ Length _____ Cramps _____
Discharge _____ Work or School Missed _____ Pain Meds necessary _____

Number of pregnancies _____ Live Births _____ Miscarriages _____ Stillbirths _____
Difficult Deliveries _____ Cesarean Deliveries _____ D&Cs _____
Last Pap _____ Any abnormal paps _____ Last mammogram _____

Social History

Do you smoke and how much? _____ How long? _____
Do you drink alcoholic beverages? _____
Do you use drugs? _____

Sexual History

Are you active presently? _____ Method of Birth Control? _____
Is Intercourse painful? _____ Any history of sexual diseases? _____

Family History

Prostate, colon, ovarian, breast or uterine cancer _____
Diabetes, Anemia, Heart Disease or High Blood Pressure _____

Preventive Health:

Do you wear seatbelts? _____
Helmet when biking? _____
Exposure to chemicals? _____
Have you been physically or sexually abused? _____
Do you wish to be tested for AIDS? _____
Do you have a living will? _____
Have you had a recent cholesterol test? _____
Have you had a rectal exam or colonoscopy? _____
If you smoke, have you tried or would you like help trying to quit? _____
Do you feel you have a drinking or drug problem? _____