## Patient Medical History

Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Appt. Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Provider you are seeing\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Date of Birth \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ Name of Primary Care Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications**Please list all medications or treatments you are currently taking. Including over-the-counter or herbal drugs.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Conditions | Yes | No | Condition | Yes | No |
| Thyroid Disease |  |  | Kidney/Bladder Disease |  |  |
| Heart Disease |  |  | Diabetes |  |  |
| Hypertension |  |  | Gallbladder Disease |  |  |
| Lung Disease |  |  | Cancer |  |  |
| Anemia |  |  | Psychological |  |  |
| Blood Transformations |  |  | Liver Disease |  |  |
| Blood clots, phlebitis |  |  | Gastrointestinal |  |  |
| Migraine Headaches |  |  | Rectal |  |  |
| Urinary |  |  | Neurological |  |  |
| Autoimmune |  |  | Musculoskeletal |  |  |

|  |  |  |
| --- | --- | --- |
| Mo./Year | Procedure | Reason |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Medications | Dosage | Frequency | Reason |
| 1 |  |  |  |
| 2 |  |  |  |
| 3 |  |  |  |
| 4 |  |  |  |
| 5 |  |  |  |
| 6 |  |  |  |
| 7 |  |  |  |

**Past Surgical History**Please list all major surgeries or hospitalization in the table.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Medical History**Please answer yes/no to the following questions. Specify any yes answers in further detail below.

Alcohol Never \_\_\_\_\_\_\_\_ Yes\_\_\_\_\_\_\_\_\_\_ what, when, and how much \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Tobacco Never \_\_\_\_\_\_\_\_ Yes\_\_\_\_\_\_\_\_\_\_ what, when, and how much \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Drug Use Never \_\_\_\_\_\_\_\_ Yes\_\_\_\_\_\_\_\_\_\_ what, when, and how much \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Exercise Never \_\_\_\_\_\_\_\_ Yes\_\_\_\_\_\_\_\_\_\_ what, when, and how much \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History**

Iodine or seafood Yes \_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_ Latex Yes \_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_   
Peanuts Yes \_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_   
Medications Yes \_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_ Specify Medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies**

**Family Medical History**Are there any genetic diseases that run in your family? Yes No Please specify below in detail.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Medical Problems | Mom | Dad | Sibling | Maternal Grandpa | Maternal Grandma | Paternal Grandpa | Paternal Grandma | Mat Aunt | Mat Uncle | Pat Aunt | Pat Uncle | Child |
| Heart Disease |  |  |  |  |  |  |  |  |  |  |  |  |
| Diabetes |  |  |  |  |  |  |  |  |  |  |  |  |
| Hypertension |  |  |  |  |  |  |  |  |  |  |  |  |
| High Cholesterol |  |  |  |  |  |  |  |  |  |  |  |  |
| Stroke |  |  |  |  |  |  |  |  |  |  |  |  |
| Neurologic Disorder |  |  |  |  |  |  |  |  |  |  |  |  |
| Bleeding/Clotting Disorders |  |  |  |  |  |  |  |  |  |  |  |  |
| Cancer |  |  |  |  |  |  |  |  |  |  |  |  |
| * Breast |  |  |  |  |  |  |  |  |  |  |  |  |
| * Uterine |  |  |  |  |  |  |  |  |  |  |  |  |
| * Ovarian |  |  |  |  |  |  |  |  |  |  |  |  |
| * Cervical |  |  |  |  |  |  |  |  |  |  |  |  |
| * Colon |  |  |  |  |  |  |  |  |  |  |  |  |
| Thyroid Disease |  |  |  |  |  |  |  |  |  |  |  |  |
| Kidney Disease |  |  |  |  |  |  |  |  |  |  |  |  |
| Liver Disease |  |  |  |  |  |  |  |  |  |  |  |  |
| Endocrine |  |  |  |  |  |  |  |  |  |  |  |  |
| Psychologic Disorder |  |  |  |  |  |  |  |  |  |  |  |  |
| Autoimmune/Rheumatologic Disorders |  |  |  |  |  |  |  |  |  |  |  |  |
| Other Genetic Disorders |  |  |  |  |  |  |  |  |  |  |  |  |
| Birth Defect |  |  |  |  |  |  |  |  |  |  |  |  |
| Pelvic Relaxation/Prolapse |  |  |  |  |  |  |  |  |  |  |  |  |

**Obstetrical History**How many pregnancies have you had?\_\_\_\_\_\_\_\_\_\_\_ Please list them all and the outcome of each below.

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Date | Gestational weeks | Length of labor | Type of delivery | Sex M/F | Birth weight | Place of Birth | Preterm Y/N | Complication |
| 1 |  |  |  |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |  |  |  |
| 4 |  |  |  |  |  |  |  |  |  |
| 5 |  |  |  |  |  |  |  |  |  |

**Gynecologic History**At what age did you start having Periods?\_\_\_\_\_\_\_\_\_\_\_ What is your Period Duration?\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Last Menstrual Period \_\_\_\_\_\_\_\_\_\_\_ Date of last Pap \_\_\_\_\_\_\_\_\_\_\_\_\_  
Date of Prior Menstrual Period \_\_\_\_\_\_\_\_\_\_\_ Date of last Mammogram \_\_\_\_\_\_\_\_\_\_\_\_\_  
Do you have Regular Periods? How often?\_\_\_\_\_\_\_\_\_\_\_ Date of last Bone Scan \_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Condition | Yes | No | Condition | Yes | No |
| Painful Periods |  |  | Problem with intercourse |  |  |
| Other Symptoms during a period |  |  | Breast discharge/tenderness/lumps |  |  |
| Heavy Bleeding |  |  | Infertility |  |  |
| Bleeding between cycles |  |  | Birth Control |  |  |
| Abnormal Vaginal Discharge/Itch |  |  | Permanent Sterilization |  |  |
| History of STD’s |  |  | Hormone Therapy |  |  |
| History of abnormal Pap Smears |  |  | Pelvic relaxation/prolapse |  |  |
| Sexually active |  |  | Other gynecologic issues |  |  |

This form completed by me the patient and is accurate to the best of my knowledge:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Patient Signature Date