MEDICAL HISTORY

SPECIFY YEARS OF BIRTH
MARK (X) FOR HEALTH

PLACE AN AGE, IF KNOWN, IN APPROPRIATE COLUMN FOR ANY ILLNESS THAT YOU OR THE RELATIVES LISTED HAVE NOW OR EVER HAD.

	YEAR OF BIRTH OR AGE	GENERALLY HEALTHY	AIDS	ALLERGIES OR ASTHMA	ANEMIA	BLEEDING TENDENCIES / BRUISING	CANCER (BREAST, OVARIAN OR CERVICAL)	CLOTTING FACTORS	DEEP VEIN THROMBOSIS	DIABETES	EPILEPSY / SEIZURES	GLAUCOMA	GOUT	HEART TROUBLE	HEPATITIS	HIGH BLOOD PRESSURE	HPV	KIDNEY OR BLADDER ILLNESS	NERVOUS BREAKDOWN	OSTEOPOROSIS	PULMONARY EMBOLISM	RHEUMATISM OR ARTHRITIS	STOMACH OR DUODENAL ULCER	STROKE	THYROID	TUBERCULOSIS	OTHER	FOR DECEASED RELATIVES LIST CAUSE AND AGE AT DEATH.
YOURSELF																												
FATHER																												
MOTHER																												
BROTHERS																												
SISTERS																												
SPOUSE																												
CHILDREN																												
MATERNAL GRANDMOTHER																												
MATERNAL GRANDFATHER																												
PATERNAL GRANDMOTHER																												
PATERNAL GRANDFATHER																												

NAME ______________________________

HOW DO YOU WISH TO BE ADDRESSED ______________________ AGE __________

DATE OF BIRTH __________ PLACE ______________ **REFERRED BY** ______________

CURRENT OCCUPATION ______________ PREVIOUS OCCUPATION ______________

RELIGION ______________ HOME PHONE __________ WORK PHONE __________

SINGLE ❒ MARRIED ❒ SEPARATED ❒ REMARRIED ❒ WIDOWED ❒ DIVORCED ❒

HIGHEST GRADE COMPLETED________ DEGREE(S) AFTER HIGH SCHOOl______________

FAMILY DOCTOR ______________________________

HUSBAND'S NAME______________ HUSBAND'S OCCUPATION ______________

SPECIFY YOUR AGE AT ONSET FOR ANY OF THE FOLLOWING

____ ECZEMA
____ DIVERTICULITIS
____ MEASLES
____ RHEUMATIC FEVER
____ HEPATITIS
____ PANCREATITIS
____ BRONCHITIS
____ GERMAN MEASLES (RUBELLA)

____PHLEBITIS
____EMPHYSEMA
____HERNIA
____EYE DISEASE
____CHICKEN POX
____MITRAL VALVE PROLAPSE
____APPENDICITIS
____MUMPS

____DEPRESSION
____COLITIS
____PNEUMONIA
____SCARLET FEVER
____MONONUCLEOSIS
____GALL BLADDER
____HEMORRHOIDS
____BROKEN BONES

CURRENT MEDICATIONS

____

____

____

ALLERGIES TO MEDICATIONS

____

____

____

EXERCISE: ❒ NONE ❒ REGULARLY ❒ OCCASIONALLY

ALCOHOL: ❒ NONE ❒ DAILY ❒ WEEKLY ❒ SPECIAL OCCASIONS

SMOKE: (packs per day) ❒ 0 ❒ 1/2 ❒ 1 ❒ 1 1/2 ❒ 2 ❒ MORE

RECREATIONAL DRUGS: ❒ NO ❒ YES ______________

NAME ______________________________

SURGICAL HISTORY

LAST: TB TEST ____________ CHEST X-RAY ______________

DATE OF LAST TETANUS IMMUNIZATION __________ WAS IT MORE THAN 10 YEARS AGO? ❐ YES ❐ NO

TRANSFUSION ______ UNITS REACTION? ❐ YES ❐ NO

LIST OF MEMBERS OF FAMILY WHO DIED IN SURGERY OR WHO HAD ANESTHETIC COMPLICATIONS

____

____

YOUR SURGERY

AGE	YEAR	SURGERY	PHYSICIAN	HOSPITAL	COMPLICATIONS	OUTCOME

NON SURGICAL HOSPITALIZATION AND ILLNESSES

AGE	YEAR	CONDITION	PHYSICIAN	HOSPITAL	COMPLICATIONS	OUTCOME

HEIGHT ______ WEIGHT ______ IDENTIFYING FEATURES: HAIR ______ EYES ______ SCARS ______________

DO YOU HAVE ANY MEDICAL CONDITIONS NOT ALREADY NOTED ON THESE FORMS? ______________

____

____

ARE THERE ANY TOPICS YOU WOULD LIKE ADDRESSED? ______________

____

____

MENSTRUAL HISTORY

AGE AT FIRST PERIOD ______ CYCLE EVERY ______ DAYS, FLOW OF ______ DAYS, PADS/TAMPONS PER DAY (HEAVY FLOW) ______

PAIN WITH PERIODS? ❐ YES ❐ NO AGE OF PAIN ONSET __________ RELIEF WITH ______________

ABNORMAL BLEEDING? ❐ YES ❐ NO INFERTILITY PROBLEMS? ❐ YES ❐ NO

CONTRACEPTION: CURRENT METHOD ______________________________

PAST METHODS: PILL DIAPHRAGM CONDOM IUD FOAM RHYTHM WITHDRAWAL DEPO PROVERA SPONGE OTHER ________

OBSTETRIC FAMIL Y HISTORY

	RELATIONSHIP
STILLBORN OR NEONATAL DEATHS	
BIRTH DEFECTS (DEAF, CLEFT PALATE, ETC.)	
DOWN'S SYNDROME	
MENTAL RETARDATION	
CONSANGUINITY (INTERMARRIED BLOOD RELATIVES)	
BLOOD DISEASES (HEMOPHILIA, SICKLE CELL, ANEMIAS)	
MUSCULAR DISEASES	
EPILEPSY	
CYSTIC FIBROSIS	
TWINS	

FAMILY BACKGROUND

- ❐ SCOT
- ❐ WELSH
- ❐ ENGLISH
- ❐ IRISH
- ❐ MEDITERRANEAN
- ❐ GREEK
- ❐ ITALIAN
- ❐ GERMAN
- ❐ AFRICAN AMERICAN
- ❐ ORIENTAL
- ❐ JEWISH
  - ❐ ASHKENAZIC
  - ❐ SEPHARDIC

YOUR PREGNANCIES: ______ FULL TERM (37+ WEEKS) ____ 20-38 WEEKS ____ UNDER 20 WEEKS ____ CHILDREN LIVING

YOUR AGE AT DELIVERY	YEAR	PHYSICIAN	HOSPITAL	WEEKS GESTATION	HOURS LABOR	ANESTHESIA	SEX	BIRTH WEIGHT	VAGINAL / CESAREAN

DETAIL ANY KNOWLEDGE OF GENETIC HISTORY HOME ______________ WORK ______________

GYNECOLOGIC HISTORY

DID YOUR MOTHER RECEIVE ANY HORMONES/ DES WHILE PREGNANT WITH YOU? ❐ YES ❐ NO ❐ DON'T KNOW

YOUR AGE AT FIRST MARRIAGE ________

GONORRHEA SYPHLIS HERPES PID (PELVIC INFLAMMATORY DISEASE) VAGINAL WARTS HPV CHLAMYDIA IUD ASSOCIATED INFECTION

ABNORMAL PAP SMEARS: DATE: ________ COLPOSCOPY? ❐ YES ❐ NO CONE BIOPSY? ❐ YES ❐ NO

CERVICAl CAUTERY OR CRYOSURGERY: DATE: ________ LEEP: DATE: ________

D & C: DATE REASON

1. ______________________________

2. ______________________________

BREAST SELF EXAM? ❐ YES ❐ NO HOW OFTEN? EVERY _____ MONTH(S) DATE OF LAST MAMMOGRAM ________

NUMBER OF MONTHS NURSED: FIRST CHILD ___ SECOND CHILD ____ OTHER ________