

Name:		Date of Birth:		Toda	Todays Date:		
Why are we seeing you to	oday?						
SURGICAL HISTORY							
Procedure		Surgery Date		Notes			
FAMILY HISTORY Please I		n the Maternal o	r Paternal si	ide.			
Relation	Problem		Relation		Problems	Problems	
MEDICATIONS If not end	ough room, please	list on back.					
Pharmacy:							
Medication/Dosage Direction			Medica	tion/Dosage	Directions		
ALLERGIES							
Drug/Allergen	Reaction		Drug/A	llergen	Reaction		

Name:	Date of Birth:

PAST MEDICAL HISTORY (only mark if yes)

	Yes	Notes		Yes	Notes
ADHD			Heart Attack/MI (angina)		
Abdominal Pain			Heart Disease		
Abnormal Weight Loss			Heart Murmur/Valve Disorder		
Affective Disorders			Hemorrhoids		
Alcoholism			Hepatitis (Acute or Chronic)		
Allergies			Hernia(s)		
Anemia			High Cholesterol		
Anorexia			Hypertension		
Anxiety Disorder			Hyperthyroidism		
Aortic Aneurysm			Hypothyroidism		
Appendicitis			Incontinence: Fecal		
Appetite, poor			Incontinence: Urinary		
Arrhythmia			Indigestion		
Arthritis			Kidney Disease		
Asthma/Breathing Problems			Leg/Foot Ulcers		
a-fib			Liver Disease		
atrial flutter			MRSA		
Bladder or Kidney Problems			Measles		
Bleeding Disorder			Migraine Headaches		
Bloating			Miscarriage		
Blood Diseases			Mononucleosis		
Bowel changes			Mouth sores		
Breast Mass/Cyst			Multiple Sclerosis		
Broken Bones			Mumps		
Bronchitis			Muscle/Joint/Bone Problem		
Bulimia			Nasal Trauma		
CVA//Stroke			Nausea Alone		
Cancer			Nausea/Vomiting		
Carotid Disease			Organ Transplant		
Cataracts			Osteopenia		
Chemical/Drug Dependency			Osteoporosis		
Chickenpox			Pacemaker		
COPD			Peptic Ulcers		
Chronic Pain			Peripheral Vascular Problem		
Constipation			Pneumonia		
Coronary Artery Disease			Polio		
Deep Vein Thrombophlebitis			Poliomyelitis		
Depression			Post-Menopausal		
Developmental or Behavioral			Prostate Problems		
Disorders					
Diabetes			Psychiatric Care		
Dialysis			Pulmonary Embolism		
Diarrhea			Rectal Bleeding		
Difficulty swallowing			Reflux Disease		
Digestive Problems			Rheumatic Fever		

Seizures or Convulsions Seizures or Convulsions									ı		
Serious/Traumatic Injuries	Diverticulitis										
Emotional Problems Sexually Transmitted Disease Emphysema Skin Cancer/Problems Epilepsy Sleep Apnea (snoring) Sleep Apnea (snoring) Sleide Attempt Sacitide Attempt Sa	Ear or Hearing Problems										
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Name:	Date of Birth:
FEMALE PATIENTS ONLY:	
GYN HISTORY	

First day of Last Period				Notes	
Age at First Child				Notes	
Current Birth Control Method				Notes	
Frequency of Cycle (Q days)				Notes	
Age at Menarche (First Menstruation)				Notes	
Flow	Light	Med	Heavy	Notes	
Duration of Flow (days)				Notes	
If Post-Menopausal, Age at Menopause				Notes	
Menses Monthly				Notes	
Date of last Pap?				Notes	
Date of last Mammogram				Notes	
Do you do self-breast exam?	Yes	No		Notes	

PAST PREGNANCIES

Date	Gestational Age (Weeks)	Labor Length (Hours)	Sex	Delivery Type c/section or vaginal	Outcome Full-Term Birth Pre-Mature Birth Abortion Miscarriage Ectopic Fetal Demise	Anesthesia General Local Epidural Spinal None	Delivery Place	Complications