Medical History

Name: _____ Age: _____ Medication Allergies: _____

Last Menstrual Period: _____ _____

Medical Biography: Please put a check mark by any of the following that you have/had a history of:

- ○ Arthritis
- ○ Bleeding Problems
- ○ Cancer _____
- ○ Diabetes
- ○ Epilepsy
- ○ Glaucoma
- ○ Heart Trouble
- ○ Heart Murmur
- ○ Hypertension
- ○ Rheumatic Fever
- ○ Kidney Disease
- ○ Neurological Problems
- ○ Nervous Condition
- ○ Phlebitis
- ○ Pregnancy, Normal
- ○ Pregnancy, Abnormal
- ○ Respiratory Problems
  - ○ Asthma
  - ○ Emphysema
  - ○ Tuberculosis
- ○ Stroke
- ○ Constipation
- ○ Diarrhea
- ○ Rectal Bleeding
- ○ Difficulty Swallowing
  - ○ Solids
  - ○ Liquids
- ○ Gallbladder Problems
- ○ Hepatitis
- ○ Jaundice
- ○ Liver Disease
- ○ Pancreatitis
- ○ Tarry, Black stools
- ○ Ulcer(s)
- ○ Vomiting
- ○ Vomiting Blood

Do you take Aspirin, Arthritis medication or Coumadin? Yes _____ No _____ How Much? _____

Have you ever been told you need to take antibiotics before dental work? Yes _____ No _____

Surgical Biography: Please put a check mark by any of the following surgeries you have had and year :

- ○ Appendectomy _____
- ○ Tonsils/Adenoids _____
- ○ Gallbladder _____
- ○ Hernia _____
  - ○ Type _____
- ○ Chest _____
- ○ D&C _____
- ○ Hysterectomy _____
- ○ Ovary _____
- ○ Tubal Ligation _____
- ○ Joint Replacement _____
- ○ Joint _____
- ○ Colon/Stomach _____
- ○ Hemorrhoids _____
- ○ Lung _____
- ○ Spine _____
- ○ Thyroid _____
- ○ Heart/Valve _____
- ○ Other _____

_____

Obstetrical Biography:

Total # Pregnancies _____ # Term Deliveries _____

Preterm Deliveries _____ # Miscarriages _____

Please list the birthdate, sex, birth weight, and method of delivery for your children below:

	Birthdate	Sex	Birth Weight	Vaginal/C-Section
1.				
2.				
3.				
4.				

Please be sure both sides are completed

Medical History

Social History:

Job Description: _____

Do you Smoke? No _____ Yes _____ How Much? _____

Do you drink? No _____ Yes _____ How Much? _____

Family History: Please check if there is family history of the following and indicate the family member affected.

- ○ Heart disease _____
- ○ Hypertension _____
- ○ Diabetes _____
- ○ Epilepsy _____
- ○ Tuberculosis _____
- ○ Colon Polyps _____
- ○ Gallbladder Disease _____
- ○ Kidney Disease _____
- ○ Liver Disease _____
- ○ Colon/Rectal Disease _____
- ○ Stroke _____
- ○ Breast Cancer _____
- ○ Uterine Cancer _____
- ○ Other Cancer _____
- ○ Other _____

Screening Information:

Do you do annual stool guaiac? (Checking stool for blood with special card) No _____ Yes _____

Date of last mammogram: _____ Ordering Physican: _____

Date of last chest X-Ray: _____ Ordering Physican: _____

Date of last Pap Smear: _____ Ordering Physican: _____

Date of last complete physical exam: _____

Current method of contraception: _____

Date of last tetanus immunization: _____

Date of last colonoscopy: _____

Recent X-Rays and Date: _____

Recent Laboratory Tests and Date:

Ultrasound: _____

Barium Enema : _____

Upper GI: _____

CT Scan: _____

Cardiac Cath:_____

Symptoms (Current) : _____

_____

_____

Family Doctor: _____

Referring Doctor: _____ Other Specialists : _____

Please be sure both sides are completed