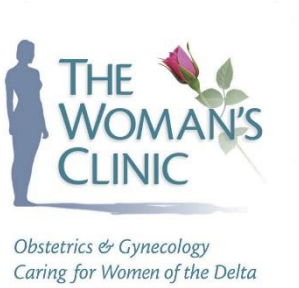

PATIENT MEDICAL HISTORY

Today's Date: _____

Name: _____ Date of Birth: _____ Pt. #: _____

(1)PROBLEM LIST/PAST MEDICAL:

1. When was your last menstrual period? _____
2. Do you suffer from any of the following:

☐Blood Pressure ☐Asthma ☐Thyroid ☐Diabetes ☐Heart Problems ☐Breast Cancer
☐GYN Cancer ☐Other _____

(2)ALLERGIES:

1. Are you allergic to any medications? If so, please list: _____
_____
2. Do you have any other allergies? If so, please list: _____
_____
3. Are you allergic to latex? ☐YES ☐NO

(3)FAMILY HISTORY:

Please check any that apply and state whether the person is immediate family (mother, father, sister, brother, maternal/paternal grandparents).

☐Hypertension (blood pressure) _____

☐Heart Disease _____

☐Diabetes _____

☐Thyroid _____

☐Asthma _____

☐Cancer _____

☐Other _____ _____

(4)PAST SURGICAL HISTORY:

1. Have you had any operations in the past? If so, please list the operation and the date of the operation:

SURGERY	DATE
_____	_____
_____	_____
_____	_____
_____	_____

(5)DIAGNOSTIC STUDIES:

1. Date of most recent pap smear? _____ Where? _____
2. Date of most recent mammogram? _____ Where? _____
3. Date of most recent bone density study?_____ Where? _____
4. Date of most recent colonoscopy? _____ Where? _____
5. Date of most recent cholesterol screening? _____ Where? _____

(6)HEALTH MAINTENANCE:

1. Flu Vaccine ☐YES ☐NO When? _____
2. Pneumovax ☐YES ☐NO When? _____
3. Tdap ☐YES ☐NO When? _____
4. Gardasil ☐YES ☐NO When? _____ How many injections? _____

(7)SOCIAL HISTORY:

1. Do you drink? ☐YES ☐NO If so, how much? _____
2. Do you smoke? ☐YES ☐NO ☐NEVER If so, how much? _____
3. Do you use illegal drugs? ☐YES ☐NO If so, what kind? _____
4. What is your current method of birth control? _____

(8)MEDICATIONS:

1. Pharmacy Preference: _____ City: _____
2. Are you currently on any medications? If so, please list them below (include dosage and how you take them):

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____

(9)PREGNANCY/BIRTH HISTORY:

1. How many times have you been pregnant? _____
2. How many living children do you or did you have? _____
3. How many abortions and/or miscarriages have you had? _____

Is there any other important medical information that is not listed above? _____
_____
_____
_____
_____