

# Medical History

Today's Date: / /

Name:

Chart #

Medications (Prescription, Over the Counter, Vitamins, Herbs, etc.)			<input type="checkbox"/> None		
Drug name	How many times a day?	mg (Dosage)	Drug name	How many times a day?	mg (Dosage)

**Past and Current Medical History**

Please place "X" on any problems you have had in the past or problems you are having currently.

- 1 \_\_\_ High blood pressure
- 2 \_\_\_ High cholesterol
- 3 \_\_\_ Diabetes
- 4 \_\_\_ Asthma
- 5 \_\_\_ Allergies/allergic rhinitis/Hay fever
- 6 \_\_\_ Cancer
- 7 \_\_\_ Heart disease
- 8 \_\_\_ Ulcers
- 9 \_\_\_ Hemorrhoids
- 10 \_\_\_ Colitis
- 11 \_\_\_ Hepatitis
- 12 \_\_\_ Hyperthyroidism (too much thyroid hormone)
- 13 \_\_\_ Hypothyroidism (too little thyroid hormone)
- 14 \_\_\_ Migraines
- 15 \_\_\_ Kidney diseases
- 16 \_\_\_ Arthritis
- 17 \_\_\_ Low back pain
- 18 \_\_\_ Anxiety
- 19 \_\_\_ Depression or \_\_\_ NONE
- 20 \_\_\_ Anemia
- 21 \_\_\_ Alcohol abuse
- 22 \_\_\_ Drug abuse
- 23 \_\_\_ Gout
- 24 \_\_\_ Other, please name.

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**Do you have allergies to any medication?**

No     Yes    If yes, fill out below.

Medication	Symptom
1	
2	
3	
4	

**Have you had any operations?**

No     Yes    If yes, fill out below.

	Year
Tonsillectomy	
Hernia Repair	
Wisdom Teeth Removal	
Other:	

**Have you ever been hospitalized overnight?**  
(ER visits without admission or Child Birth do not count.)

No     Yes    If yes, fill out below.

Problem	Year

**Did/do your relatives have any medical problems?**  
For Example.... Cancer, High Blood Pressure, Diabetes, Stroke, Heart attack, Depression

Relative		Problems (age started)			
Father	<input type="checkbox"/> No <input type="checkbox"/> Yes	1. ( ) 2. ( ) 3. ( )			
Mother	<input type="checkbox"/> No <input type="checkbox"/> Yes	1. ( ) 2. ( ) 3. ( )			
Brothers	<input type="checkbox"/> No <input type="checkbox"/> Yes	1. ( ) 2. ( ) 3. ( )			
Sisters	<input type="checkbox"/> No <input type="checkbox"/> Yes	1. ( ) 2. ( ) 3. ( )			
Paternal Grand Father	<input type="checkbox"/> No <input type="checkbox"/> Yes	1. ( ) 2. ( ) 3. ( )			
Paternal Grand Mother	<input type="checkbox"/> No <input type="checkbox"/> Yes	1. ( ) 2. ( ) 3. ( )			
Maternal Grand Father	<input type="checkbox"/> No <input type="checkbox"/> Yes	1. ( ) 2. ( ) 3. ( )			
Maternal Grand Mother	<input type="checkbox"/> No <input type="checkbox"/> Yes	1. ( ) 2. ( ) 3. ( )			

**List your children and the year they were born.  None**

Child Name	Gender M/F	Birth Year	Medical Problem No/Yes (explain)	
1	M/F		<input type="checkbox"/> No	<input type="checkbox"/> Yes
2	M/F		<input type="checkbox"/> No	<input type="checkbox"/> Yes
3	M/F		<input type="checkbox"/> No	<input type="checkbox"/> Yes
4	M/F		<input type="checkbox"/> No	<input type="checkbox"/> Yes

**Complete your Social History.**

1 **Are you a :**  never smoker---skip to question #2  former smoker  current smoker

\* If **former smoker**, how long has it been since you last smoked?  
 <1 month  1~3 months  3~6 months  6~12 months  1~5 yrs  5~10 yrs  >10 yrs

\* If **current smoker**, do you smoke everyday?  No  Yes

\* If **current smoker**, how many cigarettes a day do you smoke? \_\_\_\_\_

\* If **current smoker**, when is your first cigarette from the time you wake up in the morning?  
 5min  6~30min  31~60min  after 60min

\* If **current smoker**:  You are ready to quite.  Thinking about quitting.  Not ready to quit.

\* If **current smoker**, would you like us to fax your information to a smoking counselor to help?  No  Yes

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2 **Did you have a drink containing alcohol in the past year ?**  No---skip to question #3  Yes

\* If yes, how often did you have a drink containing alcohol in the past year?  
 Never  Monthly or less  2~4 times a month  2~3 times a week  4 or more times a week

\* If yes, how many drinks did you have on a typical day when you were drinking in the past year?  
 1~2  3~4  5~6  7~9  10 or more

\* If yes, how often did you have 6 or more drinks during one occasion in the past year?  
 Never  Less than monthly  Monthly  Weekly  Daily or almost daily

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3 **Do you use drugs? (marijuana, cocaine, crack, etc.)**  No  Yes **If yes, explain:** \_\_\_\_\_

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4 **What is your occupation?** \_\_\_\_\_

5 **If you had sex with someone, it will be with members of the:**  
 Opposite Sex  Same Sex  Both  Neither

6 **You are**  Single or  Married  
 If single,  Divorced  Spouse died  Live with a partner  None of these

7 **Name of your spouse or partner, if any.**  
 First Name \_\_\_\_\_ Last Name \_\_\_\_\_

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8 **When was your last Pap Smear?** \_\_\_\_\_  
 Have you ever had an abnormal Pap Smear result?  No  Yes **when/type** \_\_\_\_\_ / \_\_\_\_\_