

CONFIDENTIAL MEDICAL HISTORY

DATE _____
 NAME _____
 DOB _____ AGE _____ HEIGHT _____
 SS# _____ MARITAL STATUS _____
 FAMILY MD _____

UPDATE	INITIALS					
	DATE					

AGE PERIOD BEGAN _____ PERIODS OCCUR _____ PERIODS LAST _____ DAYS

MEDICATION ALLERGIES AND REACTIONS _____

FOOD OR ENVIRONMENTAL ALLERGIES _____

CURRENT PRESCRIPTIONS OR OVER-THE-COUNTER MEDICATIONS (INCLUDE DOSAGE) _____

OPERATIONS: WHAT TYPE / WHEN _____

HOSPITALIZATIONS (DATE AND DIAGNOSIS) _____

PREGNANCIES _____ FULL TERM DELIVERY _____ PRETERM DELIVERIES _____

MISCARRIAGE _____ ABORTION _____ LIVING CHILDREN _____

MEDICAL HISTORY AND HEALTH HABITS

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Kidney or Bladder Infections | <input type="checkbox"/> Gall Bladder Problems | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Hearing Defects | <input type="checkbox"/> Depression | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Abnormal Pap Smear |
| <input type="checkbox"/> German Measles (3 day) | <input type="checkbox"/> Asthma | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Sexual Problems |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Anemia | <input type="checkbox"/> Seizures | <input type="checkbox"/> Mitral Valve Prolapse
(If yes, do you require antibiotics with dental work? _____) |
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> History of Cancer |
| <input type="checkbox"/> Excessive Bleeding After Injury or Surgery | <input type="checkbox"/> Neurological Problems | <input type="checkbox"/> High Cholesterol | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Headaches | <input type="checkbox"/> Genital Herpes | |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Genital Warts | |
| | | <input type="checkbox"/> HIV Exposure | |

Any other health problems? If so, what? _____

Do you wear glasses? _____ Contacts? _____ Do you smoke? _____ Amt. per day? _____

Do you perform Self Breast Exam? _____ Do you drink alcohol? _____ Weekly amt? _____

Do you exercise? _____ Type? _____ Amt? _____ Do you feel you have a problem with drug or alcohol use? _____

Do you have routine dental exams? _____ Do you use drugs? _____

How many meals do you eat daily? _____ Do you wear a seat belt? _____

CONTRACEPTIVE USE

Do you currently use any of the following:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Depo Provera | <input type="checkbox"/> Natural Family Planning | <input type="checkbox"/> Tubal Ligation | <input type="checkbox"/> Do you have a female partner? _____ |
| <input type="checkbox"/> Birth Control Pills | <input type="checkbox"/> Condoms | <input type="checkbox"/> Partner Vasectomy | |
| <input type="checkbox"/> Diaphragm | <input type="checkbox"/> Other (foam, vaginal suppositories) | <input type="checkbox"/> None | |

FAMILY HISTORY

- Adopted? Yes No
- | | | |
|--|--|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Check if any blood relatives have the following Cancers: |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke | <input type="checkbox"/> Ovarian <input type="checkbox"/> Colon |
| | | <input type="checkbox"/> Breast <input type="checkbox"/> Other _____ |