

Welcome to our office. Please help us complete your medical record by furnishing the information below. If you have any questions regarding this form, please feel free to discuss these with the receptionist, nurse or physician.

NAME _____ **DOB** _____ **DATE** _____

Current Medications with doses:

Prescription	1	_____	6	_____
	2	_____	7	_____
	3	_____	8	_____
	4	_____	9	_____
	5	_____	10	_____
Nonprescription:	1	_____	3	_____
	2	_____	4	_____

Do You Have Any Allergies to the Following?

Medications:	1	_____	3	_____
	2	_____	4	_____
Food or Other:	1	_____	2	_____

Past Medical History (Do you have a history of any of these disorders)

	Yes	No		Yes	No
Alcoholism	_____	_____	Hepatitis	_____	_____
Anemia	_____	_____	High Blood Pressure	_____	_____
Arthritis	_____	_____	Kidney disease/Stones	_____	_____
Asthma	_____	_____	Liver Disease	_____	_____
Bleeding Problems	_____	_____	Lung Disease	_____	_____
Blood Clots	_____	_____	Mental Illness	_____	_____
Blood Transfusion	_____	_____	Migraine Headaches	_____	_____
Cancer	_____	_____	Osteoporosis	_____	_____
Cholesterol Elevation	_____	_____	Pneumonia	_____	_____
Depression	_____	_____	Seizures	_____	_____
Diabetes	_____	_____	Stroke	_____	_____
Drug Abuse	_____	_____	Thyroid Problems	_____	_____
Gallstones	_____	_____	Tuberculosis	_____	_____
Glaucoma	_____	_____	Ulcers	_____	_____
Heart Disease	_____	_____	Other:	_____	_____

Childhood Illnesses

	Yes	No		Yes	No
Chicken pox	_____	_____	Whooping cough	_____	_____
Measles	_____	_____	Scarlet fever	_____	_____
Mumps	_____	_____	Rheumatic Fever	_____	_____

NAME _____ DOB _____ DATE _____

Past Surgeries and biopsies (Please list dates)

1 _____ 3 _____
2 _____ 4 _____

Hospitalizations (Please list dates)

1 _____ 3 _____
2 _____ 4 _____

Gynecologic History

Number of : Pregnancies _____ Births _____ Miscarriages _____ Abortions _____

Age at first Period _____ Age at menopause _____

Do you do monthly breast self exams? Yes _____ No _____

Please list yes or no if you have ever had:

	Yes	No		Yes	No
Abnormal mammogram	_____	_____	Hormone replacement therapy	_____	_____
Abnormal pap smear	_____	_____	Birth Control Pills	_____	_____
DES exposure	_____	_____	Sexually transmitted disease	_____	_____
Endometriosis	_____	_____	Pelvic inflammatory disease	_____	_____
Hysterectomy	_____	_____	Uterine fibroids	_____	_____

Lifestyle

Occupations _____

Have you ever been exposed to:

	Yes	No		Yes	No
Asbestos	_____	_____	Radiation	_____	_____
Smoke	_____	_____	Chemicals	_____	_____

Smoking

Have you ever smoked? _____

If yes, how old were you when you started _____

If you are a former smoker, when did you quit? _____

How many packs per day do you or did you smoke? _____

Alcohol:

How many drinks in a typical week? _____

Caffeine:

How many cups of caffeinated beverages per day? _____

Do you:	Yes	No		Yes	No
Use recreational Drugs	_____	_____	Use Sunblock	_____	_____
Exercise regularly	_____	_____	Use Seat Belts	_____	_____

NAME _____ **DOB** _____ **DATE** _____

Family History

Please list ages and health status:

Father _____ Mother _____
 Brothers _____
 Sisters _____
 Sons _____
 Daughters _____
 Grandfathers _____
 Grandmothers _____

Please list yes or no if a blood relative has had any of the following. If yes, indicate which relative (i.e., maternal aunt):

	Yes	No		Yes	No
Alcoholism	_____	_____	Leukemia	_____	_____
Anemia	_____	_____	Liver Disease	_____	_____
Arthritis	_____	_____	Lung Cancer	_____	_____
Asthma	_____	_____	Lymphoma	_____	_____
Bleeding Problems	_____	_____	Melanoma	_____	_____
Breast Cancer	_____	_____	Mental Illness	_____	_____
Colon Cancer	_____	_____	Migraine Headache	_____	_____
Cholesterol Elevation	_____	_____	Osteoporosis	_____	_____
Depression	_____	_____	Ovarian Cancer	_____	_____
Diabetes	_____	_____	Prostate Cancer	_____	_____
Heart Disease	_____	_____	Skin Cancer	_____	_____
Hepatitis	_____	_____	Stroke	_____	_____
High blood pressure	_____	_____	Tuberculosis	_____	_____
Hodgkin's disease	_____	_____	Ulcers	_____	_____
Kidney disease	_____	_____	Others	_____	_____

Preventive Health History

Immunizations (Please list dates)

Flu Shot _____
 Hepatitis A _____
 Hepatitis B _____
 Measles (MMR) _____
 Pneumococcal _____
 Tetanus _____

Please list the date-of-your-last:

Pap test _____
 Mammogram _____
 Sigmoidoscopy _____
 Eye exam _____
 Prostate exam _____
 Cholesterol _____
 TB skin Test _____
 Colonoscopy _____

NAME _____ DOB _____ DATE _____

Review of Symptoms (Please list yes or no if you have had any concerns about the following)

	Yes	No		Yes	No
General			Gastrointestinal		
Weight loss	_____	_____	Difficulty swallowing	_____	_____
Weight gain	_____	_____	Vomiting	_____	_____
Fever	_____	_____	Nausea	_____	_____
Sweats	_____	_____	Abdominal pain	_____	_____
Swollen glands	_____	_____	Constipation	_____	_____
Loss of appetite	_____	_____	Diarrhea	_____	_____
Fatigue	_____	_____	Change in bowel habits	_____	_____
Skin			Blood in Stool	_____	_____
Rash	_____	_____	Hemorrhoids	_____	_____
Bruising	_____	_____	Jaundice	_____	_____
Change in mole or freckle	_____	_____	Urinary		
Eyes			Blood in urine	_____	_____
Blurry vision	_____	_____	Painful urination	_____	_____
Red eyes	_____	_____	Incontinence	_____	_____
Double vision	_____	_____	Gynecologic		
Blindness	_____	_____	Vaginal discharge	_____	_____
Eye pain	_____	_____	Heavy menstrual periods	_____	_____
Ears			Bleeding between periods	_____	_____
Deafness	_____	_____	Musculoskeletal		
Ear drainage	_____	_____	Joint swelling or pain	_____	_____
Ear pain	_____	_____	Back Pain	_____	_____
Ringing	_____	_____	Swollen leg	_____	_____
Nose & Throat			Leg cramps	_____	_____
Sinus pain	_____	_____	Neurological		
Hoarseness	_____	_____	Headache	_____	_____
Sore throat	_____	_____	Weakness	_____	_____
Lungs			Fainting spells	_____	_____
Shortness of breath	_____	_____	Dizzy spells	_____	_____
Cough	_____	_____	Memory loss	_____	_____
Coughing Blood	_____	_____	Paralysis	_____	_____
Wheezing	_____	_____	Convulsions	_____	_____
Heart			In-coordination	_____	_____
Chest pain	_____	_____	Trouble talking	_____	_____
Palpitations	_____	_____	Psychological		
Ankle swelling	_____	_____	Anxiety	_____	_____
Breasts			Depression	_____	_____
Lumps	_____	_____	Sleep disturbance	_____	_____
Pain	_____	_____			
Nipple discharge	_____	_____			