Past Medical History Form

Patient Name_____

Female

How did you hear about us?_____

M- Mother
F- Father
MGM- maternal grand mother
MGF- maternal grandfather
PGM-paternal grandmother
PGF- paternal grandfather
MA- maternal aunt
PA- paternal aunt
MU-maternal uncle
PU- paternal uncle
B- Brother
SIS- Sister
SON-son
DA- daughter

Have you ever had or have:

		Personal History	Family History
X	**Disease**	**Date of Diagnosis/ Explanation**	**Which family member- use key**
	High blood pressure		
	High cholesterol		
	Abnormal heart rhythm		
	Heart murmur		
	Peripheral arterial disease		
	Congestive heart failure		
	Heart attack		
	Other problem with heart or arteries/veins		
	Asthma		
	Allergies		
	Blood clot in lung		
	Pulmonary high blood pressure		
	Sleep apnea (stop breathing when asleep)		
	Excessive snoring		
	Chronic sinus issues		
	COPD		
	Emphysema		
	Other lung problems		
	Stomach ulcer		
	Chronic heartburn		
	Irritable bowel syndrome		
	Crohn's disease		
	Ulcerative colitis		
	Chronic constipation		
	Hemorrhoids		
	Pancreatitis		
	Liver disease/ Hepatitis		
	Gallstones		
	Diverticulitis		
	Other problems with your digestive tract		
	Hypothyroidism		
	Hyperthyroidism		
	Diabetes		
	Osteopenia/ Osteoporosis		
	Other endocrine issues		

X	Disease	Date of diagnosis/ Explanation	Which Family Member
	Warts		
	Eczema		
	Psoriasis		
	Abnormal moles		
	Seizures		
	Migraines		
	Chronic headaches		
	Stroke or TIA		
	Dementia		
	Other neurological problems		
	Urinary leakage		
	Endometriosis		
	Fertility Problems		
	Uterine Fibroids		
	Poly cystic ovarian disease		
	Sexually transmitted disease		
	Irregular periods		
	Kidney stones		
	Gout		
	Arthritis		
	Rheumatoid arthritis		
	Fractures		
	Lupus		
	Blood transfusion		
	Clotting/ Bleeding issues		
	Anemia	What kind	
	Sickle cell trait/ Disease		
	Thalassemia		
	Anxiety		
	Bipolar Disorder		
	Depression		
	ADD/ADHD		
	Substance abuse/inc. alcohol		
	Cancer	What type/ treatment	
	Other medical issues not listed		

Surgeries

X	Surgery	Date	X	Surgery	Date
	Tonsillectomy			Hysterectomy	
	Tubes in ears			Tubal ligation	
	Appendectomy			Cataract R/L	
	Gallbladder removal			Cosmetic	
	Back Surgery			Heart Surgery	
	Joint Surgery			Hernia	
	Joint replacement			C-section	
	Other			Other	

Procedures

Have you ever had:

X	Procedure	Date	X	Procedure	Date
	Heart catheterization			Mammogram	
	Colonoscopy			Bone Density Scan	
	Upper scope (EGD)			Prostate Check or PSA	
	Echocardiogram				

Gyn

How old were you with your first period?		
Are you (or have you ever been) sexually active?	Y N	
Age of Menopause		
Do you have sex with men, women or both?		
What type of birth control do you use?		
How many Total pregnancies have you had?		Total # (including miscar/abortions) Deliveries # Miscar # Abortions #
Last Pap Smear:		Abnormal Pap? (date and treatment)
Do you perform self breast exams regularly?	Y N	
Have you had a mammogram?	Y N	Last date: Any abnormal mammo?
Have you had a bone density scan?	Y N	Date and result:
Have you had Gardasil vaccines?	Y N	Dates:
Date of last tetanus booster?		

Social

Occupation:	
Highest level of education:	
Marital Status:	**Single Partner(girlfriend/boyfriend) Engaged Married Divorced Widowed**
Number of children:	**Biological: Stepchildren: Adopted:**
Do you live by yourself or with others?	
Exercise level?	**None 1-2/week 3-4/week 5-7/week**
How many alcoholic drinks per week?	**Never Rare 0-3 4-6 7-10 11-14 >14**
Have you ever had a problem with alcohol use?	**Y N**
Diet	**Regular Vegetarian Vegan Gluten-free Other**
General Stress Level	**Low Medium High**
Have you ever smoked? Current?	**How much? How long?**
Past?	**How much? How long?**
Smokeless tobacco? Cur/Past?	**How much/ How long?**
Regular use of marijuana?	
Other illicit drugs? Past/Present?	**Any problems with controlled substances? Like prescription medications?**
Any problems with drug use?	**Y N**
Do you drink caffeine? How much per day?	**Soda? (Diet) # (Sugar)# Coffee # Tea# Energy Drinks#**

Safety

Do you use seatbelts regularly?	
Do you use sunscreen regularly?	
Do you have guns present in the home?	**If so are they locked away from children?**
Do you have a smoke alarm at home?	
Do you wear a bike helmet?	
Any history of domestic violence?	
Any history of sexual violence?	

Personal

Do you have any pets?
What do you like to do for fun or pass time?
Other things that you would like to share about yourself?

Medication Allergies/Food Allergies/Contact Allergies

Medication/Food/Contact	Reaction

Current Medications

Please list reason for taking each medication

1. _____ **5.** _____

2. _____ **6.** _____

3. _____ **7.** _____

4. _____ **8.** _____

Vitamins/ Supplements

1. _____ **3.** _____

2. _____ **4.** _____

Past Medications

Medication	Reason for taking	Medication	Reason for taking

Health Goals

Please list health goals that you would like to reach for yourself

1.
2.
3.
4.
5.

Female Review of Systems

Please circle recent symptoms and use lines below to explain. List #.

1. **Constitutional:** fatigue, poorly (malaise), fever, night sweats, weight gain or loss that doesn't make sense
2. **Eyes:** dry eyes, irritation, vision change, discharge from eyes, foreign body sensation in eyes
3. **Ears:** ear pain, ear congestion, ears popping, discharge from the ears, difficulty hearing
4. **Nose:** nasal congestion, nasal discharge, post-nasal drip, maxillary sinus pain, frontal sinus pain
5. **Mouth/Throat:** sore throat, snoring, mouth ulcer, teeth abnormalities
6. **Cardiovascular:** chest pain, shortness of breath when lying down, rapid or irregular heartbeat (palpitations), excessive sweating
7. **Respiratory:** cough, wheezing, shortness of breath
8. **Gastrointestinal:** heartburn, nausea, vomiting, diarrhea, constipation, abdominal pain, bloating
9. **Genitourinary:** pain with urination, urine leakage, foul-smelling urine, increased urinary frequency, blood in urine, abnormal vaginal discharge, abnormal periods
10. **Musculoskeletal:** muscle aches, muscle weakness, joint pain, back pain
11. **Skin:** abnormal moles, rash, abnormal skin lesions, breast lump, change in the breast skin
12. **Neurologic:** headaches, dizziness, weakness, numbness
13. **Psych** depression, anxiety, sleep disturbances, mania, feeling unsafe in relationship, alcohol or substance abuse, difficulty falling asleep, early morning waking, not feeling rested after adequate sleep, loss of interest in activities, loss of pleasure from usual activities, inappropriate feelings of guilt, decreased energy, decreased motivation, decreased concentrating ability, abnormal appetite, feeling like hurting self, feeling so badly that you wouldn't mind if you died in your sleep, feeling actively suicidal, feeling emotionally detached, feeling unique and all-powerful (grandeur), disturbing or unusual thoughts, feelings, or sensations, decreased need for sleep, impulsive behavior, pressured speech, causing anger in friends and family
14. **Endocrine:** change in weight distribution, increased hair loss, excessively dry skin, change in color of skin, feelings of weakness and fatigue, feeling more hot or cold than others, hot flashes, abnormal hair growth,
15. **Hematologic/Lymphatic** swollen glands, abnormal bruising
16. **Allergies:** runny nose, sinus pressure, itching, hives, frequent sneezing
