# MEDICAL HISTORY 1

Date ______________________

Name ______________________ Age __________ Birthdate ______________

Address ______________________ Sex ☐ Male ☐ Female

______________________ Home Phone ______________________

______________________ Work Phone ______________________

Occupation ______________________ Emergency Contact ______________________

Phone ______________________

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If married, spouse's name ______________________

Children's names and ages ______________________

## Allergies to Medications, X-Ray Dyes, or Other Substances ☐ No ☐ Yes

(If yes, please list name of medicine and type of reaction)

______________________

## Past Medical History and Review of Systems

Please check off if you have had any problems with or are presently experiencing any of the following:

☐ High Blood Pressure
☐ Diabetes
☐ Cancer
☐ Heart Disease
☐ Chest pain/chest tightness
☐ Shortness of breath
☐ Swollen ankles
☐ Palpitations
☐ Lightheadedness
☐ Frequent urination
☐ Rheumatic fever
☐ Asthma

☐ Bronchitis
☐ Pneumonia
☐ Persistent cough
☐ T.B.
☐ Hay fever
☐ Abdominal discomfort
☐ Indigestion
☐ Nausea
☐ Vomiting
☐ Constipation
☐ Diarrhea
☐ Blood in stool
☐ Ulcers

☐ Change in bowel habits
☐ Unexplained weight gain/loss
☐ Hemorrhoids
☐ Gall Bladder disease
☐ Colitis
☐ Hepatitis or jaundice
☐ Thyroid disease
☐ Head or neck radiation
☐ Headache
☐ Kidney disease
☐ Kidney stones
☐ Difficulty urinating

☐ Arthritis
☐ Low back problems
☐ Skin diseases
☐ Blood disorders
☐ Venereal diseases
☐ Anxiety
☐ Depression
☐ Anemia
☐ Alcohol abuse
☐ Drug abuse
☐ Gout
☐ Impotence or Erectile Dysfunction
☐ Other

______________________

## Gynecologic and Obstetric History

Age at onset of periods ______________ Frequency ______________ Length of period ______________

Pregnancies ______________ Births ______________ Miscarriages ______________

Prolonged or abnormal bleeding ☐ No ☐ Yes (Please describe) ______________

Leakage of urine ☐ No ☐ Yes (Please describe) ______________

Pelvic pain ☐ No ☐ Yes (Please describe) ______________

Abnormal discharge ☐ No ☐ Yes (Please describe) ______________

History of abnormal Pap smear ☐ No ☐ Yes (Please describe) ______________

This information is for use by your physician as part of your confidential medical record.

*Please continue on the next page*

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