



MEDICAL HISTORY:

Please check all conditions that apply to you or your family members

Medical Condition	You	Mother	Father	Other	Details
Alcoholism					
Asthma					
Breast Cancer					
Depression					
Diabetes					
Emphysema					
Heart Disease					
High Blood Pressure					
Heart Attack					
Colon Cancer					
Irritable Bowel Syn.					
Kidney Disease					
Melanoma					
Migraine					
Obesity					
Stroke					
Thyroid Disease					
Other					

Who is your primary care physician?

PATIENT NAME _____

Date _____ Age _____

Date of Birth _____ Marital Status M S

Reason for visit _____

Allergies _____

NO ALLERGIES

Surgical History:

Please list all surgeries and date performed:

Year of Operation	Type of Operation

Menstrual History:

Date of last menstrual period _____
(If you have gone through menopause, skip the rest of this section)

How long from the first day of your period to the first day of the next period (cycle length) _____

How many days do you have bleeding during your period _____
Cramps? _____ Diarrhea during periods? _____

Health Habits:

Date of last PAP _____ Date of last mammogram _____

Do you smoke? _____ How many packs per day? _____

Drink alcohol? _____ How much? _____

Do you take supplemental calcium? _____

Are you in danger in your home? _____

Do you need to discuss any sexual problems? _____

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Pregnancy History

Pregnancy History:

If you have never been pregnant, check here

Year	Type of Delivery	Weight of Infant	Full term?	Miscarriage or Abortion?	Complications

Current Medication Dosage and Frequency

_____	_____
_____	_____
_____	_____
_____	_____

