Confidential Medical History

Date:

Medical record label here

Demographics

Name		Age	DOB	
Address		Sex M or F	Home Phone ( )	
			Work Phone ( )	
Occupation			Emergency Phone ( )	
Spouse's name			Healthcare worker Yes or No	
Single O	Married O	Divorced O	Widowed O	Separated O

Allergies to Medications, Dyes, Contrast or other substances? Yes O No O

If yes, please list below and type of reaction.

Current medications and vitamins (include over-the-counter types)

Drug name	Dose	Drug name	Dose

Past Medical History (please circle all appropriate)

1. High blood press	2. Bronchitis	3. Bowel change	4. Arthritis or joints
5. Diabetes	6. Pneumonia	7. Weight gain/loss	8. Low back problem
9. Cancer	10. Persistent cough	11. Hemorrhoids	12. Blood disorder(s)
13. Heart disease	14. TB	15. Gall bladder problems	16. Skin problems
17. Chest pain	18. Allergies	19. Shortness of breath	20. Swollen ankles
21. Palpitations	22. Lightheadedness	23. Frequent urination	24. Rheumatoid
25. Asthma	26. Abdominal pain	27. Indigestion	28. Nausea
29. Vomiting	30. Abnormal PAP	31. Diarrhea	32. Blood in stool
33. Ulcers	34. Abnormal Mammogm	35. High cholesterol	36. Hepatitis
37. Thyroid disease	38. Head or neck problem	39. Headache / migraine	40. Kidney disease
41. Kidney stones	42. Difficulty urinating	43. Anxiety or Depression	44. Anemia
45. Alcohol issues	46. Illicit drug use	47. Gout	48. Genital infection

Please list any surgeries you may have had:

Family history (check all that apply)

Type of illness	*Which family members?*	*Alive? Y/N*	*Approx age diagnosed*
Cancer (specify type)			
High blood pressure			
Heart attack or failure			
Diabetes			
Stroke			
Cholesterol			
Bypass surgery			
Heart failure			
Other			

Gynecologic and Obstetric History

Age of onset of periods?		Frequency and length of periods?			
Number of pregnancies?		Any abnormal (between) bleeding?	Yes	No	
Number of births?		Any change of discharge?	Yes	No	
Number of miscarriages?		Are you currently sexually active?	Yes	No	
Gestational diabetes?		Age at first intercourse?			
Eclampsia / pre-eclampsia?		How many lifetime sexual partners?	none	5 or less	6 or more
Have you reached menopause?		Are you trying for pregnancy?	Yes	No	Heck no
Est. date of last PAP?		Est. date of last mammogram?			
Est. date of last menses?		Type of birth control?			

Immunization history (check all you have had)

Pneumococcal	Yes	No	When?	Shingles	Yes	No	When?
Hepatitis B	Yes	No	When?	Influenza (flu)	Yes	No	When?
Tetanus	Yes	No	When?	Human Papillioma	Yes	No	When?
Do you often travel overseas?	Yes	No	Where?	Do you eat raw food (seafood, etc.)	Yes	No	Type?

Prevention

	Y	N		Y	N
Do you wear seatbelts?	☐	☐	Do you smoke	☐	☐
Do you drink alcohol?	☐	☐	Do you keep firearms at home?	☐	☐
Do you drink coffee or tea?	☐	☐	Do you have children at home?	☐	☐
Do you use drugs?	☐	☐	Do you drive after drinking alcohol?	☐	☐
Have you been tested for AIDS?	☐	☐	Would you like an AIDS test?	☐	☐
Are you a blood donor?	☐	☐	Would you like information on donating blood?	☐	☐
Do you have a living will?	☐	☐	Would you like information on a living will?	☐	☐
Have you ever been in an abusive relationship?	☐	☐	Are you presently in an abusive relationship?	☐	☐
Do you work with hazardous chemicals?	☐	☐	Do you get your eyes tested regularly?	☐	☐
Have your teeth been checked this past year?	☐	☐	Do you care for small children?	☐	☐
Are you dieting?	☐	☐	Are you vegetarian?	☐	☐