

MEDICAL HISTORY INFORMATION

Name:				Date:	Medications:
Sex:	DOB:	Age:	Ht:	Wt:	
Known Drug Allergies:					
Date of last Physical:					
Surgeries:					
Date Last Pap:		Date Last Mammogram:			
Number of Pregnancies:		LMP:			
Do you or have you ever had chronic problems with:				Explanation:	
	YES	NO			
Eyes					
Ears					
Headaches					
Nose					
Throat					
Chest					
Breathing					
Heart					
Chest					
Lungs					
Stomach					
Food Digestion					
Intestines					
Rectum					
Constipation					
Diarrhea					
Bladder					
Kidneys					
Urination					
Ovaries					
Uterus					
Cervix					
Menstruation					
Blood Disorders					
Immune Deficiency Disorder					
Testicles/Penis					
Sexually Transmitted Disease					
Skin					
Legs/Arms					
Depression					
Emotion Problems					
Sleep Problems					
Personal/Work Stress					
Please indicate family history: Mother, Father, Sister, Brother, Grandmother, Grandfather					
Cancer:		Heart Disease		HIV:	
Breast:		Heart Attack:		Ulcers:	
Prostate:		High Blood Pressure:		Gallbladder Disease:	
Other:		Diabetes:		Migraines:	
Stroke:		Blood Disease:		TB:	
Diabetes:		Mental Illness:		Thyroid:	
Seizures:		Asthma:			
Smoke?		# of Cigarettes:			
Drink Alcohol?		# of drinks/day		# drinks/wk	