

NAME _____ DATE OF BIRTH _____ TODAY'S DATE _____

PERSONAL MEDICAL HISTORY

Have you ever had the following:

- | YES | NO | |
|-----|----|--|
| — | — | MIGRAINES |
| — | — | THYROID PROBLEMS |
| — | — | ASTHMA |
| — | — | BREAST DISEASE |
| — | — | HIGH BLOOD PRESSURE |
| — | — | BLOOD CLOTS (arms, legs, lungs) |
| — | — | STROKE |
| — | — | ANEMIA OR BLOOD DISEASE |
| — | — | HIGH CHOLESTEROL |
| — | — | SICKLE CELL DISEASE |
| — | — | BLOOD TRANSFUSION |
| — | — | HEPATITIS OR MONO |
| — | — | LIVER DISEASE |
| — | — | KIDNEY/BLADDER PROBLEMS |
| — | — | INFECTION OF UTERUS OR FALLOPIAN TUBES |
| — | — | FREQUENT VAGINAL INFECTION |
| — | — | GENITAL WARTS |
| — | — | STD (Gonorrhea, Syphilis, Chlamydia, Herpes) |
| — | — | IV DRUG USE |
| — | — | OVARY PROBLEMS |
| — | — | DIABETES |
| — | — | CANCER |
| — | — | PHYSICAL/SEXUAL ABUSE |
| — | — | EMOTIONAL/PSYCH PROBLEMS |
| — | — | MRSA |

FAMILY HISTORY

Have your parents, grandparents, brothers/sisters, had any of the following:

- | YES | NO | |
|-----|----|---------------------------|
| — | — | BREAST OR OVARIAN CANCER |
| — | — | OTHER CANCER (TYPE _____) |
| — | — | DIABETES |
| — | — | HEART ATTACK OR STROKE |
| — | — | HIGH BLOOD PRESSURE |
| — | — | HIGH CHOLESTEROL |

MENSTRUAL AND PAP HISTORY

FIRST DAY OF LAST MENSTRUAL PERIOD _____
 # OF WEEKS BETWEEN PERIODS _____
 HOW MANY DAYS DO YOU FLOW? _____
 HAVE YOU EVER HAD AN ABNORMAL PAP? YES NO
 If so, when? _____

PREGNANCY HISTORY

HOW MANY TIMES HAVE YOU BEEN PREGNANT?
 (INCLUDING NOW) _____ # OF LIVE BIRTHS _____
 # OF MISCARRIAGES OR ABORTIONS _____
 PROBLEMS WITH PREGNANCIES:

 CURRENT BIRTH CONTROL METHOD:

MEDICATIONS (Strength & Dosage)

NATURAL SUPPLEMENTS/HERBS

HOSPITALIZATIONS/SURGERIES & DATES

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES (medications, skin, latex)

SEXUAL PARTNERS MALE FEMALE BOTH

HABITS

ALCOHOL YES NO AMOUNT _____
 TOBACCO YES NO AMOUNT _____
 RECREATIONAL DRUGS YES NO AMOUNT _____
 CAFFEINE YES NO AMOUNT _____

DO YOU EXERCISE REGULARLY? YES NO
 HOW OFTEN? _____
 TYPE OF EXERCISE _____

NAME _____

OTHER SYMPTOMS

Are you currently having problems with (*please circle*):

GENERAL: FEVER / CHILLS / DECREASED ENERGY / WEIGHT GAIN / WEIGHT LOSS

EARS, NOSE, THROAT: SINUS PROBLEMS / RINGING EARS / SORE THROAT

CARDIOVASCULAR: PALPITATIONS / CHEST PAIN / SWELLING IN LEGS

RESPIRATORY: SHORTNESS OF BREATH / CHRONIC COUGH / WHEEZING

GASTROINTESTINAL: DIARRHEA / CONSTIPATION / HEARTBURN / RECTAL
BLEEDING / NAUSEA

GENITOURINARY: PAINFUL INTERCOURSE / LEAKING URINE / PAIN WITH
URINATION

MUSCULOSKELETAL: JOINT PAIN / BACK PAIN / MUSCLE WEAKNESS

BLOOD PROBLEMS: EXCESSIVE BRUISING / BLOOD CLOTS IN VEINS

OTHER: