OWEN BELL MD, APC

PERSONAL MEDICAL HISTORY

NAME: _____ DATE OF BIRTH: _____ TODAY'S DATE: _____

PERSONAL HISTORY			FAMILY HISTORY		
YES	NO		YES	NO	
◯	◯	Migraines	◯	◯	Breast or Ovarian Cancer
◯	◯	Thyroid Problems	◯	◯	Other Cancers:
◯	◯	Asthma	◯	◯	Heart Attack or Stroke
◯	◯	Breast Disease	◯	◯	High Blood Pressure
◯	◯	High Blood Pressure	◯	◯	High Cholesterol
◯	◯	Blood Clots (arms, legs, lungs)	MENSTRUAL AND PAP HISTORY		
◯	◯	Stroke	First day last menstrual period:		
◯	◯	Anemia or blood disease	Num. of weeks between periods:		
◯	◯	High Cholesterol	How many days do you flow:		
◯	◯	Sickle Cell Disease	Have you ever had an abnormal PAP:		
◯	◯	Blood Transfusion	If so, when:		
◯	◯	Hepatitis or Mono	PREGNANCY HISTORY		
◯	◯	Liver Disease	How many times have you been pregnant (including now)?		
◯	◯	Kidney or Bladder Problems			
◯	◯	Infection of Uterus or Fallopian Tubes	Number of live births:		
◯	◯	Frequent Vaginal Infections	Number of miscarriages or abortions:		
◯	◯	Genital Warts	Problems with Pregnancies:		
◯	◯	STD (gonorrhea, syphilis, chlamydia, herpes)			
◯	◯	IV Drug Use			
◯	◯	Ovary Problems			
◯	◯	Diabetes			
◯	◯	Cancer	What do you use for birth control?		
◯	◯	Physical or Sexual Abuse			
◯	◯	Emotional of Psychological problems			

MEDICATIONS	NATURAL SUPPLEMENTS/HERBS	HOSPITALIZATIONS, SURGERIES & DATES
(Please List Below)		

ALLERGIES	HABITS			
(Medications, skin, latex)		YES	NO	AMOUNT
	Alcohol	○	○	
	Tobacco	○	○	
	Recreational Drugs	○	○	
	Caffeine	○	○	

Sexual Partners

Male ☐ Female ☐ Both ☐

Do you exercise regularly?

How often:

Type of Exercise:

OTHER SYMPTOMS					
Please select all current symptoms that apply:					
GENERAL		EARS, NOSE, THROAT		CARDIOVASCULAR	
Fever	☐	Sinus Problems	☐	Palpitations	☐
Chills	☐	Ringing Ears	☐	Chest Pain	☐
Decreased Energy	☐	Sore Throat	☐	Swelling in legs	☐
Weight Gain	☐				
Weight Loss	☐				
RESPIRATORY		GASTROINTESTINAL		GENITOURINARY	
Shortness of Breath	☐	Diarrhea	☐	Painful Intercourse	☐
Chronic Cough	☐	Constipation	☐	Leaking Urine	☐
Wheezing	☐	Heartburn	☐	Pain with Urination	☐
		Rectal Bleeding	☐		
		Nausea	☐		

MUSCULOSKELETAL		MENTAL HEALTH		BLOOD PROBLEMS	
Joint Pain	☐	Depression	☐	Excessive Bruising	☐
Back Pain	☐	Anxiety	☐	Blood Clots in Veins	☐
Muscle Weakness	☐	Emotional Changes	☐		

OTHER SYMPTOMS: