

Medical History Form

Name: _____ Date of Birth: _____ Gender: F M

Current Health Status

Do you consider yourself generally in good health at this time? Yes No

Do you regularly see a health care professional for any condition? Yes No

If 'Yes', what condition(s) _____

Are you currently taking any medications? Yes No

(Please include all prescribed, over-the-counter, herbal medicines, supplements, etc. whether taken regularly or intermittently.)

If 'Yes', please indicate the name, dose, and frequency of the products:

Name:	Dose:	Frequency (incl. daily vs. as needed)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had any problems (allergies, intolerance) with any medications or vaccines? Yes No

If 'Yes', please indicate name of medication and type of reaction:

Name:	Type of Reaction (e.g. rash, diarrhea, trouble breathing)
_____	_____
_____	_____
_____	_____

Past Medical History

Have you had a history of:

(Please check all that apply and indicate the year or your age of onset/diagnosis.)

- | | |
|--|---|
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> stroke |
| <input type="checkbox"/> high cholesterol | <input type="checkbox"/> recurrent headaches, migraines |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> asthma |
| <input type="checkbox"/> chest pain | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> heart disease | <input type="checkbox"/> constipation |
| <input type="checkbox"/> heart attack | <input type="checkbox"/> abdominal pain |
| <input type="checkbox"/> leg pains, cramping | <input type="checkbox"/> mood swings, anxiety, depression |
| <input type="checkbox"/> leg/feet swelling | <input type="checkbox"/> sleep disturbances |
| <input type="checkbox"/> glaucoma | <input type="checkbox"/> eating disorders |

Have you had any major medical conditions not listed above? Please specify, include age of onset and duration, and whether you were hospitalized:

Have you had any major injuries or accidents? Were you hospitalized?

Have you had any surgeries or major procedures? Please indicate type, date and institution:

Type of Surgery/Procedure:	Date:	Clinic/Hospital:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever had or received treatment for, or do you suffer from (please check all that apply):

<input type="checkbox"/> Measles	<input type="checkbox"/> Cholera	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Mumps	<input type="checkbox"/> Malaria	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Gallbladder Disease
<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Chemical Dependence
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Cancer
<input type="checkbox"/> Tonsillitis	<input type="checkbox"/> Tuberculosis*	<input type="checkbox"/> Bowel Disease
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Typhoid Fever	<input type="checkbox"/> Nervous Breakdown
<input type="checkbox"/> Polio	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Psychiatric Problems
<input type="checkbox"/> Jaundice	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Anemia	<input type="checkbox"/> Gout	<input type="checkbox"/> Blood Transfusion
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Other: _____

*Have you ever had a "positive" PPD (skin test for TB, tuberculosis)? Yes No

Obstetric / Gynecologic History

Age of first period: _____ Age of last period (if menopausal): _____
 1st day of last period: _____ Duration of last period: _____
 Frequency of periods: _____ Are they at regular intervals? Yes No
 Associated symptoms (PMS, nausea, cramping, clotting): _____

When was your most recent routine gynecological examination? _____

Have you ever had any abnormal Pap smears? Yes No

If 'yes', when? _____ Have you had follow-up since? _____

Have you ever had a mammogram? Yes No

If 'yes', when was your last mammogram? _____

Have you ever had any abnormal mammograms? Yes No

Are you currently pregnant? Yes No

What method of birth control are you using? _____

How many times have you been pregnant? _____

How many children do you have (please include adoptions)? _____

Please indicate type of delivery (vaginal, assisted, cesarean section) and date(s):

Type of Delivery:	Date:
_____	_____
_____	_____
_____	_____

Have you used any Assisted Reproductive Technology to achieve pregnancy? Yes No

If 'yes', please indicate what method(s), date(s) and duration:

Have you or are taking any hormone replacement (prescribed or herbal preparation)? Yes No

If 'yes', please indicate type/name of product and start/duration of treatment:

Name/Type of Hormone Replacement:	Date started:	Date stopped:
_____	_____	_____
_____	_____	_____

