

PATIENT PAST MEDICAL HISTORY

Name: (Please Print Clearly) _____ Date of Birth: _____ Age _____

Your home phone number: (_____) _____ Work Number: (_____) _____ Ext: _____

Do you have a Living Will? () Yes () No If not, would you like information regarding Advanced Healthcare Directives? () Yes () No

Are you an organ donor? () Yes () No Organ(s) _____ Are you Jehovah Witness? () Yes () No

Race or nationality of parents: _____ Your place of birth: _____

Your occupation: _____ For how long? _____

ALLERGIES: Have you had allergies or sensitivity to medications, food or other substances: () Yes () No If yes, please list substance and describe reaction: _____

PERSONAL MEDICAL HISTORY: (Please circle all that apply)

Abnormal Bleeding	Arthritis	Asthma	Any sexually transmitted disease	Bloody or Black Stools	Cancer	Changes In Menses
Change in Bowel Movement	Diabetes	D & C	Elevated Cholesterol	Gallstones	Glaucoma / Cataract	Heart Disease
Hemorrhoids	Hepatitis	High Blood Pressure	Hiatal Hernia	Irritable Bowel	Kidney Disease	Kidney Stones
Nervous Disorder	Ovarian Cyst	Pneumonia	Rectal Bleeding	Reflux	Rheumatic Fever	Recurrent Urinary Infection
Skin Problems	Stroke	Tuberculosis	Ulcers	Vein Trouble	Other	

Have you ever had a serious injury, broken bone(s), etc. () Yes () No If so, please describe: _____

Have you ever had a previous operation: () Yes () No If so, list, including dates: _____

FAMILY HISTORY	How Many?	Living (Yes / No)	Age or age at death	Present health or cause of death
Father	Living?			
Mother	Living?			
Spouse				
Brother(s)				
Brother(s)				
Sister(s)				
Sister(s)				
Children				
Children				
Is there a family history of: (Please circle all that apply)				
Abnormal Bleeding	Cancer	Diabetes	Heart Disease	High Blood Pressure
Kidney Disease	Nervous Disorder	Stroke	Other	

IMMUNIZATION (Check all that apply)	Yes	No	Don't Know	Had Disease	Date of immuniz. or disease
Chicken Pox					
Flu					
Pneumonia					
Tetanus Booster					
Other					

MENSTRUAL HISTORY: Age at onset: _____

Date of last period: _____ Periods are: Regular / Irregular

Date of last Pap smear: _____ Number of pregnancies: _____

Number of miscarriages: _____ Date(s): _____

MISCELLANEOUS: Have you traveled or lived outside of the United States or Canada? If yes, when and where: _____

Have you ever received a blood transfusion? () Yes () No If yes, date and reason: _____

Your Signature: _____ Today's Date: _____