Date:

PT. MEDICAL HISTORY FORM

Name:___________________________________ **PCP and/or Referring MD**______________________________

Do You Have/Had:
(Please circle) Allergies Arthritis Asthma COPD Heart disease Diabetes Glaucoma High cholesterol
High blood pressure Kidney disease Thyroid Cancer: ____________________________
Any other problems:____

New/Current Meds: ____

List any operations you have had:____

Hysterectomy? Yes No **At what age?**_________ **Ovaries are**: in out

Do You Have? (please circle)

Fever, chills
Changes in vision, blurred vision
Sore throat, nasal congestion, nasal discharge, headaches
Lumps, tenderness, nipple discharge
Chest pain, cardiac murmurs, irregular heart beats
Shortness of breath, wheezing
Nausea, vomiting, diarrhea, constipation, blood in stools
Urgency, frequency, painful urine
Rash, itching, new skin lesions
Tingling or numbness, incoordination, seizures
Bone pain, back pain, joint pain
Excessive thirst, excessive urine, cold intolerance, heat intolerance, weight gain, weight loss
Anxiety, depression
Easy bleeding, easy bruising, lymph node enlargement or tenderness
Sinus allergy symptoms, frequent illnesses

Drink alcohol? Never Rarely Occasionally Weekly Daily **Do you use tobacco?** Yes Never Former

Age at first period?___________ Last period/ age of menopause?____________
How many times have you been pregnant?_______ How many children have you had?_______
Age at first childbirth?________ Did you breast feed? N Y

Your Family History:

Do your parents, siblings, or children have breast or ovarian cancer? N Y

Cancers: Who, What kind, and What age?____
____

Diabetes Heart disease High blood pressure Other:________________________________

----FOR OFFICE USE ONLY:--

Reason for visit:____Allergies:_________________________

B/P_________ Temp_________ Wt.__________ Ht._________ LMP___________
Physician Notes: