

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: