

## Medical History Form (1)

Date\_\_\_\_\_

Name\_\_\_\_\_ Date of Birth\_\_\_\_\_ Age\_\_\_\_\_

Address\_\_\_\_\_

City\_\_\_\_\_ State\_\_\_\_\_ Zip\_\_\_\_\_

Pharmacy\_\_\_\_\_ Phone\_\_\_\_\_

**Chief Complaint**\_\_\_\_\_

**Current Medications**\_\_\_\_\_

**Allergies**\_\_\_\_\_ Are you allergic to Latex? Y N

**Past Medical History** (diabetes, kidney disease, DVT etc.)\_\_\_\_\_

**Previous Surgeries** (with year)\_\_\_\_\_

**Family History** (cancer, diabetes, DVT/PE etc.)\_\_\_\_\_

### **Social History**

Tobacco Use Y N Started Age/Year\_\_\_\_\_ Stopped Age/Year\_\_\_\_\_

Quantity Per Day\_\_\_\_\_ Date of Last Use\_\_\_\_\_

Alcohol Use Y N Beer Y N Wine Y N

Quantity Per Day\_\_\_\_\_ Date of Last Use\_\_\_\_\_

Illicit Drugs Y N Date of Last Use\_\_\_\_\_

### **Menstrual History**

Age of Onset\_\_\_\_\_ Date of Last Period\_\_\_\_\_ Periods – regular Y N

Do you have a history of an abnormal pap exam? Y N When?\_\_\_\_\_

Difficulty with periods?\_\_\_\_\_

### **Pregnancies**

# of Children Born Alive\_\_\_\_\_ # of Premature Births\_\_\_\_\_

# of Cesarean Sections\_\_\_\_\_ # of Stillborns\_\_\_\_\_

# of Miscarriages\_\_\_\_\_ # of Abortions\_\_\_\_\_

### **Personal Habits**

Do you exercise regularly? Y N How many days a week?\_\_\_\_\_

Do you suffer with Anorexia? Y N Do you suffer with Bulimia? Y N

Have you ever been physically abused? Y N

Do you have a history of/ or been treated for depression? Y N

## Medical History Form (2)

### Review of Systems

**Constitutional Systems**

Fever	Y	N
Chills	Y	N
Headache	Y	N
Weight Loss	Y	N

**Eyes**

Blurred vision	Y	N
Double Vision	Y	N

**Neurological**

Tremors	Y	N
Dizzy Spells	Y	N
Seizures	Y	N

**Endocrine**

Thirst	Y	N
Too Hot/Cold	Y	N
Lethargic	Y	N

**Gastrointestinal**

Abdominal Pain	Y	N
Nausea	Y	N
Vomiting	Y	N
Change in Stools	Y	N

**Sexually Transmitted Infections**

Chlamydia	Y	N
Gonorrhea	Y	N
HPV	Y	N
Genital Warts	Y	N
Hepatitis A/B/C	Y	N
Herpes	Y	N
HIV	Y	N
Syphilis	Y	N

**Cardiovascular**

Chest Pain	Y	N
Palpitations	Y	N
Shortness of Breath	Y	N

**Allergic/Immunologic**

Chicken Pox	Y	N
Hay Fever	Y	N

**Respiratory**

Wheezing	Y	N
Cough	Y	N
Sputum	Y	N

**Musculoskeletal**

Joint Pain	Y	N
Stiffness	Y	N
Cramps	Y	N

**Genitourinary**

Pain w/ Urine	Y	N
Leaking Urine	Y	N
Frequency	Y	N
Pressure	Y	N

**Genital**

Bumps	Y	N
Masses	Y	N
Ulcers	Y	N
Burning	Y	N
Pain w/ Intercourse	Y	N
Itching	Y	N
Discharge	Y	N

My signature certifies that the above information is accurate and true to the best of my knowledge.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Parent if minor)