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PATIENT INFORMATION

Date: _____

First Name: _____ Middle Initial: ____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Birthdate: _____ Age: _____ SS#: _____

Home Phone #: _____ Cell #: _____ Work#: _____

Employer: _____

Occupation: _____

Husband's Name: _____

Birthdate: _____ SS#: _____

Employer: _____ Work Phone#: _____

Family Physician: _____

Primary Insurance: _____

Name of Primary Insured: _____ Primary Insured DOB: _____

Secondary Insurance: _____

Name of Primary Insured: _____ Primary Insured DOB: _____

ALLERGIES: _____

_____

Medications Presently Taking: _____

_____

If Minor: Parent/Guardian – Name and Relationship: _____

Emergency Contact – Name and Relationship: _____

Address: _____ Phone No: _____

Occupational History:

What type of work do you do? _____

Do you work around chemicals? _____

Social History:

Do you smoke? YES/NO If yes, how much? _____

Do you drink alcohol? YES/NO If yes, how much ? _____

Do you use illicit drugs? YES/NO if yes, what type? _____

Medical History: Do you have or have you had any of the following, please check?

Diabetes ___
Malignancies ___
High Blood Pressure ___
Heart Disease ___
Rheumatic Fever ___
Scarlet Fever ___
Pulmonary Disease ___
Mitral Valve Prolapse ___
Renal Disease ___

Recurrent Urine Infections ___
Venereal Disease ___
Phlebitis ___
Varicose Veins ___
Neurologic Disorders ____
Thyroid Disorder ____
Endocrine Disorder ___
Hepatitis/Yellow Jaundice ____
Blood Disorders ____

Mononucleosis ___
Asthma ___
Seizures ___
Anemia ___
Hayfever ____
Mumps ___
Measles ___
Chickenpox ___

List any other medical problems not listed above: _____
_____

Have you ever had any operations? YES/NO (Type & Date) _____
_____
_____

Have you ever received a blood transfusion? YES/NO If so, When & Why _____
_____

Have you ever taken hormones? YES/NO (list type – include Birth Control Pills, Estrogens, Progesterones, thyroid, and Insulin): _____
_____

Have you or any family members had any of the following?

	Patient	**Family**
Congenital Anomalies	___	___
Genetic Disease	___	___
Infertility	___	___

Family History: (List is living & well, or deceased, an any medical problems)

Father: _____

Mother: _____

Brothers: Total # ___ Illnesses: _____

Sisters: Total # ___ Illnesses: _____

Husband: _____

Sons: Total # ___ Illnesses: _____

Daughters: Total # ___ Illnesses: _____

Others: (Grandparents, Aunts & Uncles) _____
_____
_____

Systemic History: Have you ever had any of the following? Please check

HEENT:
Frequent sore throats ____
Hearing problems___
Visual problems___
Glaucoma ___
False teeth ___
Nosebleeds ___

URINARY:
Kidney infections ___
Bladder infections ___
Blood in urine ___
Kidney stones ___

ENDOCRINE:
Thyroid problems___
Diabetes ___
Menopausal symptoms ___

CARDIOVASCULAR:
Heart murmur ___
Rheumatic fever ___
Varicose veins ___
Blood clots ___
Anemia ___
High blood pressure ____
Shortness of breath ___
Do you bleed easily ___

NEUROLOGICAL:
Frequent headaches ___
Dizziness ___
Fainting spells ___

PULMONARY:
Chest problems ___
Pneumonia ___
Tuberculosis ___
Chronic cough ___

GASTROINTESTINAL:
Food intolerance ____
Chronic indigestion____
Liver problems___
Gallbladder problems ___
Yellow Jaundice ___
Bloody stools or vomitus ___
Bowel habit changes ___
Chronic diarrhea ____
Colitis ___

MISCELLANEOUS:
Bone problems ___
Recent weight changes ___
Skin disease ___
Muscle problems ___
Breast problems ___
Depression ___
Psychiatric care ___

Menstrual History:

Age first started menstruating? _____ Last menstrual period? _____ Was it normal? _____

Previous menstrual period? _____ How many days from the 1st day of one period to the 1st day of the next? _____

How many days do your periods last? _____

How many pads or tampons do you use on the heaviest day? _____ pads _____ tampons.

Are your periods painful? YES / NO Are medications used? YES / NO If so, what type? _____

Do you have any problems with bleeding between periods? YES / NO

Do you have any problems with intercourse? YES / NO

When was your last pelvic exam and pap smear? _____

Was the pap smear normal? YES / NO If no, explain: _____

Have you ever had any of the following?
Vaginitis ____ Abnormal pap smear ____
Gonorrhea ____ Genital warts/Condylomata ____
Chlamydia ____ Pelvic Inflammatory Disease ___
Herpes ____ Urine Leakage ____ If yes, describe: _____

Contraception: List dates used & any problems

Birth Control Pills: _____

IUD (type): _____

Foam: _____ Condoms: _____

Norplant: _____ Depo-Provera: _____

Diaphragm: _____ Vasectomy: _____

Rhythm: _____ Tubal Ligation: _____

Withdrawal: _____ Other: _____

Previous Pregnancies: (Not Necessary to complete if menopausal)

How many children have you had? _____ Living: _____ Deceased: _____ Stillborn: _____

Miscarriages? _____ Date: _____ Duration: _____ Operation: _____

_____ Date: _____ Duration: _____ Operation: _____

Terminations? _____ Date: _____ Duration: _____ Operation: _____

_____ Date: _____ Duration: _____ Operation: _____

Please complete for each pregnancy:

Delivery Date	**Prenatal Course** Full term? Any complications	**Type of Delivery** Vaginal, C-section, Forceps, Vacuum, Stitches?	**Complications** With labor or delivery	**Infant** Name, sex & weight

History since last menstrual period: **PATIENTS PRESENTLY PREGNANT**

When was your positive pregnancy test performed? _____ Urine _____ Blood _____

Last menstrual period? _____ Was it normal? YES / NO

Since your last period, have you had any of the following symptoms? (Please explain and include any medications or treatments used)

Headaches: _____ Edema/Swelling: _____

Nausea/Vomiting: _____ Fever: _____

Abdominal pain: _____ Exposure to German measles: _____

Urinary complaints: _____ Other viral exposures: _____

Vaginal discharge: _____ Drug Exposure: _____

Vaginal bleeding: _____ Radiation/x-ray exposure: _____

Other: _____

List type of birth control used: _____

Dates last used: _____

Please list all medications that you have used since your last menstrual period. Include often used and dosage, also include vitamins:

_____

_____

_____

_____