

MEDICAL HISTORY

Please detail any operations you have had. Please check here if none: _____

Operation	Year	Surgeon	Hospital/City/State
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

Please list all major health conditions: (i.e. high blood pressure, diabetes, hypertension, history of blood clots):

Please check if none: _____

Health Condition	_____	_____	_____
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

Please list all the drugs and medications you have taken over the past 4 weeks. (Include aspirin, birth control pills, supplements, (i.e. vitamins) and any drug or medication with or without a prescription):

Name of Drug	Dose	Number per Day/Week	List Any Side Effects
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

Please list any allergies to medications: _____

Please list any other allergies: _____

FAMILY HISTORY

The following questions concern your family medical history:

	IF LIVING		IF DECEASED	
	Age(s)	Major Medical Conditions	Age(s) at Death	Cause(s) of Death
Father				
Mother				
Brother(s)				
Sister(s)				
Son(s)				
Daughter(s)				

Please list any illnesses that run in the family: _____

Does anyone in your family have any of the following problems? (Please circle)

Heart disease High blood pressure Anesthesia complications Cancer Stroke
 Nerve problems Blood problems (anemia, abnormal bleeding) Diabetes Other: _____

Female Patients Only: GYNECOLOGICAL HISTORY

Are you pregnant? Y N Do you use birth control? Y N If yes what: _____
Have you experienced menopause or a hysterectomy? Y N If yes, what & when? _____
Date of last pap smear? _____ Date of last mammogram? _____
Age you began menstruating: _____ When was your most recent menstrual period? _____
How many periods have you had during the last 12 months? 10-12 7-9 5-6 1-6 more

CURRENT SYMPTOMS OR PROBLEMS

Please check any of the following that apply to you:

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Recent weight change | <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Fatigue/weakness | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Fever, chills | <input type="checkbox"/> Swollen legs or feet | |
| <input type="checkbox"/> Skin rash/disease | <input type="checkbox"/> Stomach pain/heartburn | |
| <input type="checkbox"/> Vision problem/eye disease | <input type="checkbox"/> Ulcers | |
| <input type="checkbox"/> Nose/throat problem | <input type="checkbox"/> Hepatitis or gallbladder disease | |
| <input type="checkbox"/> Hearing problems/ear disease | <input type="checkbox"/> Change in bowel habits (also blood in stools) | |
| <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Blood disorder or blood transfusion | |
| <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Easy bleeding or bruising | |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Kidney disease or kidney stones | |
| <input type="checkbox"/> Problems with coordination | <input type="checkbox"/> Sexually transmitted disease | |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Change in appetite or thirst | |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Shortness of breath or wheezing | |
| <input type="checkbox"/> Joint stiffness, pain or swelling | <input type="checkbox"/> Frequent cough | |
| <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Change in urinary habits (including pain, blood in urine, trouble stopping/starting your urine) | |
| <input type="checkbox"/> Difficulty in moving an arm or leg | | |
-
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HEALTH HABITS

Do you smoke cigarettes? Y N packs/day _____ For how long? _____ yrs

Do you drink alcohol? Y N drinks/wk _____

How would you describe your level of physical activity over the past six months?

- | | |
|----------------|---|
| _____ Inactive | - just daily activity |
| _____ Light | - some walking, gardening, occasional weekend recreational activity |
| _____ Moderate | - regular (3x week) moderate exercise and occasional weekend sports |
| _____ Vigorous | - regular (3-5x week) vigorous exercise and/or sports activity |
| _____ Intense | - competitive vigorous sports training |

Height _____ feet/inches Weight _____ lbs

Do you consider your current weight ideal? Y N

If no, list your ideal weight _____

Do you have questions about healthy ways to control your weight? Y N

The following questions concern your health now and in the past. Please answer every question. If you are unsure of how to answer a question, please provide the best answer you can.

In general, would you say your health is:

____ Excellent ____ Very Good ____ Good ____ Fair ____ Poor

