DOCTOR REVIEWED WITH PATIENT

____
MD SIG.

____
DATE

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PATIENT MEDICAL HISTORY FORM

Name: ______________________ **Today's date:** ______________
Date of Birth: ________ **Age:** ____ **Single** ___ **Married** ___ **Widowed** ___ **Divorced** ___
Telephone: Home (   ) ______________ **Work/Cell: (   )** ______________
Social Security No. ______________ **Email:** ______________________

Past Obstetric History:

Number of full term pregnancies? ________
Number of premature pregnancies? ________
Number of miscarriages? ________
Number of abortions?: ________
Number of living children?: ________

Last menstrual period ______________________
Last pap smear ______________________
History of abnormal pap smear/If yes, when? ______________________
Last mammogram & where it was performed ______________________
History of abnormal mammograms ______________________
History of sexually transmitted diseases ***i.e.: HPV, HIV, Syphilis, Hepatitis B, Hepatitis C, Herpes, Gonorrhea/Chlamydia.*** **(Please include when you were diagnosed and treated)**

____

Have you had any of the medical problems listed below?

Yes	No	
______	______	**severe headaches/migranes**
______	______	**serious eye,ears,nose&thoat problems**
______	______	**high blood pressure**
______	______	**heart murmur (mitral valve prolapsed)**
______	______	**asthma**
______	______	**breast cysts**
______	______	**breast cancer**
______	______	**hepatitis (B, C)**
______	______	**gall bladder stones**
______	______	**hiatal hernia**
______	______	**ulcer**
______	______	**spastic colon**
______	______	**urine infections**
______	______	**anemia**
______	______	**varicose veins**
______	______	**phlebitis**
______	______	**diabetes**
______	______	**thyroid disease**
______	______	**cancer**
______	______	**seizures**
______	______	**osteoporosis/bone loss/bone fracture**

Have you or do you have any other medical problems not noted above?

List any operations you have had. Please specify the date of the operation or your age when it was performed.

1.

2.

3.

4.

Have you ever had breast surgery or breast biopsies? If yes, provide date of procedure and type of procedure done.

<u>Family History</u>:

Please note if family members are alive and well, or specify illnesses, if deceased, please indicate age at death and cause. If known:

	Present age	health
Father	______________	______________________________
Mother	______________	______________________________
(your) Brothers	______________	______________________________
	______________	______________________________
	______________	______________________________
(your) Sisters	______________	______________________________
	______________	______________________________
	______________	______________________________

Please specify family members known to have any of the following diseases:

Breast cancer ____

Ovarian cancer ____

Colon cancer ____

High blood pressure ____________________________________

Heart disease ____

Kidney disease ____

Diabetes ____

Other ____

Do you smoke? If yes, how much? At what age did you start?

Do you drink alcoholic beverages? Never _____ Light _____ Moderate _____ Heavy _____

Do you take any medicines? If so, please specify.

Do you have any allergies to medications? If so please specify.

Have you had any blood transfusions?