

**Personal Medical History**

**Patient Identification**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Race: \_\_\_\_\_ Referring Physician: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Primary Physician: \_\_\_\_\_

**Reason for Visit**

1 In the lines below, please describe any special problems or symptoms you would like to discuss with the doctor today:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

2 How long have you had this problem?  1 week  1 month  1 yr  over 1 yr

3 What treatment have you received for this problem? \_\_\_\_\_

4 Did the treatment help?  yes  no

**Past Medical History**

Place an (X) next to any of the following problems for which you or a close family member have been treated or diagnosed:  
 (close family member = mother, father, brother, or sister only)

	personal history	family history		personal history	family history
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack or stroke	<input type="checkbox"/>	<input type="checkbox"/>	Other liver diseases	<input type="checkbox"/>	<input type="checkbox"/>
Disease of heart valves	<input type="checkbox"/>	<input type="checkbox"/>	Irritable bowel syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Other heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Pancreatitis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Stomach or duodenal ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Other lung disease	<input type="checkbox"/>	<input type="checkbox"/>	Seizure disorder	<input type="checkbox"/>	<input type="checkbox"/>
Melanoma	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Cancer _____	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric disorder	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes mellitus	<input type="checkbox"/>	<input type="checkbox"/>	Sexual abuse or domestic violence	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol or substance abuse	<input type="checkbox"/>	<input type="checkbox"/>
Kidney infection	<input type="checkbox"/>	<input type="checkbox"/>	Anemia or blood disorder	<input type="checkbox"/>	<input type="checkbox"/>
Other kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Blood clots in lungs or legs	<input type="checkbox"/>	<input type="checkbox"/>
Bladder disease	<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's disease	<input type="checkbox"/>	<input type="checkbox"/>	Elevated cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Diverticulitis or diverticulosis	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>

**Past Obstetric History**

How many times have you been pregnant? \_\_\_\_\_  
 How many children have you delivered (vaginal and cesarean)? \_\_\_\_\_  
 How many were delivered by cesarean section? \_\_\_\_\_  
 How many of your children were born prematurely? \_\_\_\_\_  
 How many miscarriages have you had? \_\_\_\_\_  
 Have you ever had an abortion?  yes  no  
 If yes, how many? \_\_\_\_\_  
 How many ectopic pregnancies have you had? \_\_\_\_\_  
 How many of your children are still living? \_\_\_\_\_  
 How many twins or multiple births have you had? \_\_\_\_\_

Place an (X) next to any of the following complications of pregnancy which you have had:

- Toxemia or preeclampsia
- High blood pressure
- Gestational diabetes
- Blood transfusion
- Stillbirth
- Other complications \_\_\_\_\_

