

PHYSICIANS' CENTER, P.A.

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MEDICAL HISTORY FORM

Date _____ Reviewed By _____
Name _____ Age _____ Date of Birth _____ Sex M F
Known Drug Allergies _____

Past Medical History & Review of Symptoms:

Please check if you have had any problems or are experiencing any of the following listed below:

- | | | |
|--|---|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Change in Bowel Habits |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Weight Gain or Loss |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Gall Bladder Disease |
| <input type="checkbox"/> Chest Pain or Tightness | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Swollen Ankles | <input type="checkbox"/> Nausea | <input type="checkbox"/> Neck/Head Radiation |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Lightheadedness | <input type="checkbox"/> Constipation | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Blood in Stool | <input type="checkbox"/> Urination Difficulty |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Skin Disease | <input type="checkbox"/> Blood Disorders |
| <input type="checkbox"/> Venereal Diseases | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Low Back Problems | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Gout |

Gynecologic & Obstetric History:

Age Onset of period _____ Frequency _____ Length _____

Pregnancies _____ Births _____ Miscarriages _____

Prolonged or Abnormal Bleeding No Yes

Describe _____

Leakage of Urine No Yes

Describe _____

Pelvic Pain No Yes

Describe _____

History of Abnormal Pap No Yes

Describe _____

History of Abnormal Mammogram No Yes

Describe _____

Please list and supply dates of:

Operations _____

Hospitalizations _____

Last Pap Smear _____ Breast Exam _____ Mammogram _____

Stool Check for Blood _____ Cholesterol Check _____ Prostate Exam _____

FAMILY HISTORY:

Has any member of your family (including grandparents and siblings) ever had the following?

ILLNESS	FAMILY MEMBER	AGE WHEN DIAGNOSED
Cancer (describe type)	_____	_____
Hypertension (high blood pressure)	_____	_____
Heart Disease	_____	_____
Diabetes	_____	_____
Stroke	_____	_____
Mental Disease (anxiety, depression)	_____	_____
Drug or Alcohol Addiction	_____	_____
Glaucoma	_____	_____
Bleeding Diseases	_____	_____

CURRENT MEDICATIONS:

Drug Name	Dosage	Drug Name	Dosage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Prevention:

What is your occupation? _____

When was your last tetanus shot? _____

Do you exercise? Yes No Type and number of times per week:

Do you smoke? Yes No If yes, how many per day? _____

Do you drink alcoholic beverages? Yes No If yes, how much per week? _____

Do you drink caffeinated beverages? Yes No If yes, how many cups per day? _____

Do you use drugs? Yes No If yes, please explain

Do you have a living will? Yes No