MEDICAL HISTORY RECORD

All information is treated as confidential unless you grant permission to release it. Please print and complete all information.

Case No	Today's Date	Birth Date	
Last Name First Name Middle	Daytime Phone		Evening Phone
Address City State Zip	Marital Status		Occupation
Emergency Contact	Phone Number	Relationship	Last Physical Exam Date
By Doctor:	Phone Number	Family/Referring Doctor	Phone Number
May I Contact either of these Yes Doctors for your past health records? No	What are your present medical symptoms?		

Family History		IF LIVING	IF DECEASED		Any blood Relatives who have or have had any of the listed conditions							
		HEALTH	Death									
	Age	Good Fair Poor	Age	Death Cause		Yes	No	Relationship		Yes	No	Relationship
Father					Asthma				Hay Fever			
Mother					Arthritis				Insanity			
Brothers Sisters					Allergies				Kidney Disease			
1 M F					Anemia				Leukemia			
2. M F					Alcoholism				Migraine			
3. M F					Bleeding Tend.				Nervous Break'n			
4. M F					Cancer				Obesity			
5. M F					Colitis				Rheumatism			
Husband					Congenital Heart				Rheumatic Fever			
Sons Daughters					Diabetes				Stroke			
1 M F					Epilepsy				Suicide			
2. M F					Goiter				Stomach Ulcers			
3. M F					High Bl. Press.				Turberculosis			
4. M F					Heart Disease							
5. M F												
6. M F												

HABITS

Do you	Yes	No	Daily Consuption
Smoke......	☐	☐	______________Pkgs.
Drink Coffee..	☐	☐	______________Cups
Drink Alcohol..	☐	☐	______________ozs.
Drink Beer.....	☐	☐	______________ozs.
Awaken Early..	☐	☐	

MEDICATIONS

Check if taken:

		Blood Thinning Pills	☐	Iron or Poor Blood Med	☐	Vitamins..............	☐
Antacids	☐	Cortisone	☐	Laxatives..............	☐	Water Pills..............	☐
Antibiotics..............	☐	Cough Medicine..........	☐	Phenobarbital..............	☐	Weight Reducing Pills	☐
Aspirin, Bufferin, Anacin	☐	Digitalis..............	☐	Shots..............	☐	Other(List)____________	
Barbiturates..............	☐	Dilantin..............	☐	Sleeping Pills..............	☐	____________	
Birth Control Pills..........	☐	Hormones..............	☐	Thyroid Med..............	☐	____________	
Blood Pressure Pills......	☐	Insulin, Diabetic Pills	☐	Tranquilizers..............	☐	____________	

Operations you have had: Year
____
____
____

Diseases you have had requiring hospitalization Year
____
____
____

Serious illnes not requiring hospitalization:____________ Year
____
____

Drugs you are allergic to:
____
____
____

Describe any serious injuries or accidents you have had:
____
____
____

	Yes	No	
Are you still having your monthly menstrual periods?..........................	☐	☐	
Have you ever had bleeding between your periods?	☐	☐	When?____________
Do you have very heavy bleeding with your periods?	☐	☐	When?____________
Do you feel bloated and irritable before your period?	☐	☐	
Are you now or have you ever taken birht control?	☐	☐	When?____________
Have you ever had a miscarriage?..	☐	☐	When?____________
Do you regularly have the cervix cancer screenings?..........................	☐	☐	Date of last screening?____________

How many children born alive?..............____________
How many stillbirths?..............................____________
How many premature births?..................____________
Date of last menstrual period........____________
How many miscarriages?.........................____________
How many cesarean operations?...........____________

Additional information to make the doctor aware of:
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____
____
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