Personal Medical History

(Current Problems and History of Past Health)

Name:_____ Date of Birth (MM/DD/YYYY):_____

HCN:_____ Best Contact Number:_____

Please circle any health concerns YOU have now or have had in the past. If an important concern is not listed, mark the general heading "other" and give details below.

Circulatory

- Stroke
- Heat Disease
- High BP
- Anemia
- High Cholesterol
- Blood Clots
- Brain Aneurysm
- Severe Circulation Problems (i.e., Legs)
- Aortic aneurysm

Infectious diseases

- Measles Mumps
- Chicken Pox
- Whooping cough
- Hepatitis
- +HIV
- STD
- TB (Tuberculosis)

Neurologic

- **Seizures**
- **Migraines**
- **Hearing problems**
- **Vision Problems**
- **Vertigo**

Respiratory

- Asthma
- Emphysema/COPD

Endocrine

- Diabetes
- Thyroid Disease

Mental Health

- Alcohol/drug problems
- Depression/Anxiety
- Eating Disorder /Body image

Reproductive/GYN

- # of pregnancies
- Fertility problems
- Abnormal Pap Smear
- Pelvic Inflammatory disease

Gastrointestinal

- Bowel Disease
- Liver Disease
- Gallstones
- Frequent abdominal Pain

Musculoskeletal

- Arthritis
- Joint Problems
- Chronic Back Pain
- Fibromyalgia

Other

- Abuse/Violence

Family Medical History

Did any of your blood relatives (Parents, grandparents, siblings, aunts/uncles) have any of the following health problems? If so, please circle below. If an important condition is not listed, circle the major heading and give details below.

Cancer	***Circulatory***	Musculoskeletal
Blood (i.e. Leukemia, Lymphoma)	Stroke	Arthritis
Brian	Heat Disease	
Breast	High BP	
GI (Stomach, colon)	High Cholesterol	Respiratory
Genito-Urinary (kidney, bladder)	Blood Clots	Asthma
GYN (uterus, ovarian)	Brain Aneurysm	Emphysema/COPD
Lung	Severe Circulation Problem	
Prostate	Aortic Aneurysm	
Skin (Melanoma)		Skin
Other		Eczema
		Psoriasis
	Gastrointestinal	
	Bowel disease	
	Liver disease	
Endocrine	***Mental Health***	Other
Diabetes	Alcohol/Drug Problems	Genetic abnormalities
Thyroid Disease	Depression/Anxiety	

List of medications currently taken

_____

_____

_____

_____

_____

Preventative health

Please indicate if/when you have had any of the following (if applicable)

Pap smear_____

Bone Density Test_____

Colorectal screening (i.e. Colonoscopy or Fecal Occult Blood test):_____

Mammogram; _____

Prostate/PSA test: _____

Tetanus Vaccine/Booster; _____

Social History

Do you smoke? _____ How much (# cig/Day) _____

Do you drink alcohol? _____ how much? (Drinks/week) _____

Do you exercise? (What do you do? How often)

_____

Occupation: _____

Marital Status: _____

Do you have any children? If yes, how many: _____

Do you use contraception? (condoms/pills/IUD/other: _____)

Diet? (Generally healthy, generally unhealthy/Vegetarian/Other: _____)

Thank you for completing this questionnaire. Please indicate here if there are any other important health concerns in your personal history that was not addressed in this questionnaire or mention to them to the physicians.