

Medical History Form

Name _____

Please complete All 4 Pages

Today's Date _____

Date of Birth _____

Your answers on this form will help your clinician understand your medical concerns and conditions better. **Best estimates** are fine if you cannot remember specific details.

REASON FOR YOUR VISIT: _____

In the last year have you had any MRI's, CT Scans, Ultrasounds, or Lab work we should obtain? Where? Did you bring any results with you today? _____

Additional Problems/Concerns: _____

CURRENT MEDICATIONS: Prescription and non-prescription medicine, vitamins, home remedies, birth control pills, herbs:

Medication	Dosage (mg)	Frequency	Date Started	Prescribing MD/NP

(Please record additional items on back)

Many medications have a generic that is the same as the brand name. If Dr. Corning or the nurse practitioner feels the generic is the same, are you okay with her prescribing the generic? Yes to generic No (Brand Only)
 Do you prefer prescriptions in a 30 day supply or a 90 day supply? Preferred pharmacy _____

ALLERGIES OR REACTIONS TO MEDICINES/FOODS/OTHER AGENTS/ENVIRONMENTAL:

Allergen (Drugs, food, environment)	Reaction or Side Effect

WOMEN'S GYNECOLOGIC HISTORY:

# pregnancies	# deliveries vaginal ___ C-section ___	# abortions	# miscarriages
1st day (date) most recent period:		Frequency of periods:	
Age at first period:		Length of each period:	

Current birth control method (you or partner):	Are you happy with your birth control?
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PERSONAL MEDICAL HISTORY:

How would you rate your general health?	Poor	Fair	Good	Excellent
Health Maintenance Screening Tests				
Cholesterol Screening (last)	Date	Results		
Mammogram (last)	Date	Results		
Ever abnormal? Yes No	Details:			
Pap smear (last)	Date	Results		
Ever abnormal? Yes No	Details:			
Stool test for blood (last)	Date	Results		
Sigmoidoscopy or Colonoscopy (last)	Date	Results		
DEXA (bone density test)(last)	Date	Result		

PERSONAL ILLNESSES OR HEALTH PROBLEMS: Please indicate (✓) whether you have had any of the following problems and the approximate date of illness or diagnosis.

✓	Illness/Problem (date)	✓	Illness/Problem (date)	✓	Illness/Problem (date)
	Arthritis/other Rheumatologic Disease		Headaches		Intestinal (GERD, IBS, Ulcers, Crohn's)
	Neurologic problems		Heart Disease/Heart Attack		Lung (Asthma, Chronic Bronchitis, COPD, Emphysema)
	Bleeding/Clotting problems		Heart valve replacement		Gynecological Cancers (ovary, uterus, tubes, cervix, etc.)
	Depression/Anxiety		High Blood Pressure		Muscular problems
	Diabetes		High cholesterol		Thyroid (hypo-, hyper-, Goiter)
	Any Other (please list)				

SOCIAL HISTORY: Please circle or check (✓) the answer.

Current Occupation:					Exercise Regularly: Yes No How often? How long (minutes)? If no, why?				
Marital Status		Divorced	Domestic Partner		Married	Single		Widowed	
Sexual Activity Are you sexually active?		Not Currently	Yes	No	Current sex partners:			Male	Female
More than 4 sexual partners in your lifetime?			Yes	No	Have you had sexually transmitted diseases (STDs)?			Yes	No
Have you changed sexual partners since your last exam?			Yes	No	Other concerns?			Yes	No
Interested in being screened for sexually transmitted diseases?			Yes	No					
Alcohol Use	Yes	No	Drinks per week:		Is alcohol a concern for you or others?			Yes	No
Drug Use	Do you use recreational drugs?		Yes	No	Have you ever used needles?			Yes	No
Tobacco Use	Never	Quit: ___ Date		Current Smoker: ___ Packs/day ___			# of years ___		
Other Tobacco:				Are you interested in quitting?			Yes	No	

Safety: Is violence at home a concern for you?	Yes	No	Have you ever been abused?	Yes	No
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REVIEW OF BODY SYSTEMS: Please check (✓) any current problems you have on the list below.

Constitutional	<input type="checkbox"/>	Chills	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	Weight gain
	<input type="checkbox"/>	Excessive thirst	<input type="checkbox"/>	Fever	<input type="checkbox"/>	Weight loss
	<input type="checkbox"/>	Excessive urination	<input type="checkbox"/>	Night Sweats	<input type="checkbox"/>	
Eyes	<input type="checkbox"/>	Recent changes in vision	<input type="checkbox"/>		<input type="checkbox"/>	
Head, ears, nose, throat	<input type="checkbox"/>	Hay fever or allergies	<input type="checkbox"/>	Problems w/teeth/gums	<input type="checkbox"/>	Sinus pain/congestion
Breasts	<input type="checkbox"/>	Changes in skin	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	Lumps
	<input type="checkbox"/>	Pain	<input type="checkbox"/>		<input type="checkbox"/>	
Cardiovascular	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	
Respiratory	<input type="checkbox"/>	Cough	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	Wheezing
Gastrointestinal	<input type="checkbox"/>	Abdominal pain	<input type="checkbox"/>	Bowel changes	<input type="checkbox"/>	Nausea
	<input type="checkbox"/>	Bloating	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	Rectal bleeding
	<input type="checkbox"/>	Blood in stools	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	Vomiting
Genitourinary/ Gynecological	<input type="checkbox"/>	Urinary frequency	<input type="checkbox"/>	Pain with urination	<input type="checkbox"/>	Urinary retention
	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	Sexual dysfunction	<input type="checkbox"/>	Vaginal discharge
	<input type="checkbox"/>	Urinary incontinence	<input type="checkbox"/>	Urgency	<input type="checkbox"/>	
Skin	<input type="checkbox"/>	Changes to existing skin lesions or moles	<input type="checkbox"/>		<input type="checkbox"/>	Rash
Neurological	<input type="checkbox"/>	Dizzy/lightheaded	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	
Psychiatric	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Difficulty sleeping
Heme-Lymphatics	<input type="checkbox"/>	Bleeding disorder	<input type="checkbox"/>	Unexplained lumps	<input type="checkbox"/>	
Others not mentioned above	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	

SURGICAL HISTORY: (Please list all prior operations and dates – record additional items on back):

Year	Illness or Operation	Complications

FAMILY HISTORY: Please indicate (✓) below significant medical problems of immediate family members (parents, siblings, paternal/maternal grandparents, paternal/maternal aunts/uncles).

Medical Condition	Relationship	Medical Condition	Relationship
Arthritis		Breast cancer	
Blood clots		Cervical cancer	
Diabetes		Colon cancer	
Elevated cholesterol		Ovarian cancer	
Heart disease		Uterine cancer	
High blood pressure		Other cancer :	
Stroke			
Other not mentioned:			

IMMUNIZATIONS: Please list your most recent immunizations. Include your best estimate of month and year.

Vaccine	Date	Vaccine	Date
Influenza (1 dose annually)		Meningococcal	
Td/Tdap (1 booster Tdap, Td every 10 yrs)		Pneumovax (pneumonia) (age 65)	
Varicella (2 doses)		Shingles/Zoster (1 dose age 60)	
Measles, mumps, rubella (1 or 2 doses)			
HPV – Gardasil (3 doses)			