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Medical History Form

Your answers on this form will help us understand your medical concerns and conditions better. If you are uncomfortable with any question, do not answer it.

Name _____ Date of Birth _____ Today's date _____

1. Personal Medical History

Please indicate if you have had any of the following problems currently or in the past.

Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma/Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney disease/stones	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chronic diarrhea/IBS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver disease/Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Lung disease/pneumonia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diverticulosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pancreatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sexually transmitted disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, what age? _____			Sleep apnea	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Epilepsy or Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Gallstones	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Venereal disease/Syphilis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Gout	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid disease/Goiter	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heartburn/Acid Reflux	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tumors/Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High Cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ulcers (stomach or intestinal)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If yes to any of the above, please explain _____

When was your last Tetanus shot given? _____

2. Family History

Adopted, family history unknown.

Has anyone in your family (including grandparents, parents, brothers, sisters, or children) had any of the following conditions?

Family Relationship:

Bowel/Colon Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____	<input type="checkbox"/> Living	<input type="checkbox"/> Deceased at age _____
Breast Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____	<input type="checkbox"/> Living	<input type="checkbox"/> Deceased at age _____
Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____	<input type="checkbox"/> Living	<input type="checkbox"/> Deceased at age _____
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____	<input type="checkbox"/> Living	<input type="checkbox"/> Deceased at age _____
Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____	<input type="checkbox"/> Living	<input type="checkbox"/> Deceased at age _____
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____	<input type="checkbox"/> Living	<input type="checkbox"/> Deceased at age _____
High Cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____	<input type="checkbox"/> Living	<input type="checkbox"/> Deceased at age _____
Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____	<input type="checkbox"/> Living	<input type="checkbox"/> Deceased at age _____
Rheumatoid Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____	<input type="checkbox"/> Living	<input type="checkbox"/> Deceased at age _____
Strokes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____	<input type="checkbox"/> Living	<input type="checkbox"/> Deceased at age _____
Thyroid Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____	<input type="checkbox"/> Living	<input type="checkbox"/> Deceased at age _____
Other _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____	<input type="checkbox"/> Living	<input type="checkbox"/> Deceased at age _____

3. Personal Habits

Tobacco Use

Cigarettes: Never Former Current Smoker (Packs per day _____ # of Years _____ Quit-Date _____)
Other tobacco: Pipe Cigar Snuff Chew
Are you interested in quitting? Yes No

Alcohol Use

Do you drink alcohol? No Yes, average # of drinks per week _____
If no, have you in the past? Yes No

Drug Use

Do you use any recreational drugs, such as marijuana, cocaine, stimulants, narcotics, diet pills?
 No Yes (please circle which drugs)
Have you ever used needles? Yes No

Sexuality

Are you sexually active? Yes No Not currently
If sexually active, do you practice safe sex? Yes No
Birth control method _____
Have you ever had any sexually transmitted diseases (STD's)? Yes No
If yes, please include _____

Exercise

Do you exercise regularly? Yes No How many times per week? _____
If yes, what type of exercises? _____

Emotions

In the past year, have you had 2 weeks or more during which you felt sad, blue, or depressed; or when you lost interest or pleasure in things that you usually enjoyed? Yes No

4. Medications

Please list all your current medications, including medications and supplements not needing a prescription:
Or attach a complete list.

Medication	Dose	Directions	Taken For:	Will our office be refilling?
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No, refilled by specialist
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No, refilled by specialist
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No, refilled by specialist
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No, refilled by specialist
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No, refilled by specialist
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No, refilled by specialist
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No, refilled by specialist
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No, refilled by specialist

5. Allergies

Please list any allergies or reactions to medications:

Medication	Reaction or Side Effect
_____	_____
_____	_____
_____	_____
_____	_____

6. Operations

Have you had any operations? If yes, list:

Type of operation / Reason for operation	Hospital / Facility	Date of operation
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

7. For Women Only

Total # of pregnancies _____ # of deliveries _____ # of miscarriages _____ # of abortions _____

Age at start of menstrual period _____

Date most recent menstruation began _____

Usual length of menstrual period _____ days

Date of last Pap smear _____

Have you ever had an abnormal Pap smear? Yes No

If yes, give date and describe _____

Have you stopped having menstrual periods? Yes No If yes, when _____

Do you have regular problems with:

Irregular, painful, or heavy menstrual periods Yes No

Bleeding between periods or after menopause Yes No

Vaginal discharge, pain or itching Yes No

Hot flashes Yes No

Pain or lumps in breasts Yes No

If you see a gynecologist for your annual exams, please list their name/phone: _____

Please return to:

Ripon Family Physicians

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