PATIENT MEDICAL HISTORY

NAME OF PATIENT | BIRTHDATE | RACE | PLACE OF BIRTH-CITY, STATE/or COUNTRY | ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

HAVE YOU OR YOUR BLOOD RELATIVES EVER HAD	CHECK THE APPROPRIATE BOX YOU YES / NO	FAMILY YES / NO	PLEASE EXPLAIN
1. HIGH BLOOD PRESSURE	☐ ☐	☐ ☐	
2. HEART DISEASE (Angina, Myocardial Infarction, etc.)	☐ ☐	☐ ☐	
3. DIABETES MELLITUS	☐ ☐	☐ ☐	
4. STROKE	☐ ☐	☐ ☐	
5. LUNG PROBLEMS (ASTHMA, BRONCHITIS, ETC.)	☐ ☐	☐ ☐	
6. KIDNEY or BLADDER PROBLEMS	☐ ☐	☐ ☐	
7. THYROID DISORDERS (HYPER, HYPO, NODULES, ETC.)	☐ ☐	☐ ☐	
8. ANEMIA or BLOOD DISORDERS, BLEEDING TENDENCY	☐ ☐	☐ ☐	
9. CANCER	☐ ☐	☐ ☐	
10. VENEREAL DISEASE INCLUDING HERPES	☐ ☐	☐ ☐	
11. MENTAL DISORDERS DEPRESSION	☐ ☐	☐ ☐	
12. DO YOU TAKE ASPIRIN, NSAID'S or BLOOD THINNERS	☐ ☐	☐ ☐	LIST BELOW
13. GALLSTONES	☐ ☐	☐ ☐	
14. STOMACH PROBLEMS, ULCERS, HIATAL HERNIA	☐ ☐	☐ ☐	
15. HEPATITIS or OTHER LIVER DISEASE	☐ ☐	☐ ☐	
16. COLON POLYPS, COLITIS or CANCER	☐ ☐	☐ ☐	
17. DIVERTICULOSIS or DIVERTICULITIS	☐ ☐	☐ ☐	
18. CONSTIPATION or RECENT CHANGE IN BOWEL HABITS	☐ ☐	☐ ☐	
19. CHRONIC DIARRHEA	☐ ☐	☐ ☐	
20. BLOOD IN STOOL	☐ ☐	☐ ☐	

DO YOU SMOKE? DO YOU USE ALCOHOL? HOW MUCH? WHEN QUIT?

OPERATIONS / SURGERIES: PLEASE LIST WHEN / WHERE PERFORMED:

LIST YOUR MEDICATIONS:

LIST ANY ALLERGIES:

FOR WOMEN:
1. HAVE YOU HAD FEMALE ORGAN PROBLEMS (ABNORMAL BLEEDING? ENDOMETRIOSIS?) _____
2. HAVE YOU HAD A MAMMOGRAM? _____ WHEN ? _____ WHERE? _____
3. ARE YOU ON ANY HORMONES OR BIRTH CONTROL PILLS? (PLEASE LIST) _____
4. WHEN WAS YOUR LAST MENSTRUAL PERIOD? _____
5. HAVE YOU EVER BEEN PREGNANT?_____HOW MANY TIMES? _____

FOR MEN:
1. DO YOU HAVE DRIBBLING OR DIFFICULTY STANDING OR STOPPING URINATION?
2. HAVE TO URINATE AT NIGHT? _____ HOW MANY TIMES? _____
3. ANY PROBLEMS WITH IMPOTENCE? _____ BLOOD IN URINE? _____

NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.