

Legal Name: _____

Gender: Woman Man Other: _____

ALLERGY HISTORY

Y	N	List/Comments:
<input type="checkbox"/>	<input type="checkbox"/>	Medications
<input type="checkbox"/>	<input type="checkbox"/>	Food
<input type="checkbox"/>	<input type="checkbox"/>	Latex
<input type="checkbox"/>	<input type="checkbox"/>	Metals
<input type="checkbox"/>	<input type="checkbox"/>	Anesthesia
<input type="checkbox"/>	<input type="checkbox"/>	Other:

IMMUNIZATIONS Have you been vaccinated against the following?

Y	N		Y	N	
<input type="checkbox"/>	<input type="checkbox"/>	Rubella (MMR)	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	HPV
<input type="checkbox"/>	<input type="checkbox"/>	Other: (specify)			

MEDICATION HISTORY

List all current medications including birth control, herbal, and vitamins

FAMILY HISTORY

Y	N	
<input type="checkbox"/>	<input type="checkbox"/>	Adopted
<input type="checkbox"/>	<input type="checkbox"/>	History Unknown

Has your biological mother, father, sister, brother, grandmother, or grandfather had any of the following?

Y	N	Who?
<input type="checkbox"/>	<input type="checkbox"/>	Birth defect(s)
<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots
<input type="checkbox"/>	<input type="checkbox"/>	Cancer (specify)
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Heart attack or stroke before age 50
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol
<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Other (specify):

PERSONAL HEALTH HISTORY

Do you have or have you ever had any of the following?

Y	N	Comments:
<input type="checkbox"/>	<input type="checkbox"/>	Birth defects / genetic conditions
<input type="checkbox"/>	<input type="checkbox"/>	Cancer, specify site
<input type="checkbox"/>	<input type="checkbox"/>	Descendant of Ashkenazi Jew
<input type="checkbox"/>	<input type="checkbox"/>	Breast lump, discharge

EYES/EARS

<input type="checkbox"/>	<input type="checkbox"/>	Contact Lenses
<input type="checkbox"/>	<input type="checkbox"/>	Eye glasses
<input type="checkbox"/>	<input type="checkbox"/>	Hearing Problem

RESPIRATORY

<input type="checkbox"/>	<input type="checkbox"/>	Asthma / Breathing Problems
<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough / Tuberculosis

GASTROINTESTINAL

<input type="checkbox"/>	<input type="checkbox"/>	Stomach or bowel problems
<input type="checkbox"/>	<input type="checkbox"/>	Gall bladder disease / stones
<input type="checkbox"/>	<input type="checkbox"/>	Liver (Hepatitis, Mono, Jaundice)

Preferred Name: _____

Pronoun: He She Other: _____

PERSONAL HEALTH HISTORY (continued)

Y	N	Comments:
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CARDIOVASCULAR

<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease / Murmur
<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins
<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots/Stroke

GENITOURINARY

<input type="checkbox"/>	<input type="checkbox"/>	Bladder / kidney problems
<input type="checkbox"/>	<input type="checkbox"/>	Leaking of urine
<input type="checkbox"/>	<input type="checkbox"/>	Frequent bladder infections
<input type="checkbox"/>	<input type="checkbox"/>	Recurrent vaginal infections
<input type="checkbox"/>	<input type="checkbox"/>	Pelvic inflammatory disease
<input type="checkbox"/>	<input type="checkbox"/>	Uterine problem
<input type="checkbox"/>	<input type="checkbox"/>	Uterine fibroids
<input type="checkbox"/>	<input type="checkbox"/>	Ovarian cysts
<input type="checkbox"/>	<input type="checkbox"/>	Endometriosis
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal pap smear(s) When?
<input type="checkbox"/>	<input type="checkbox"/>	Colposcopy / LEEP / cryotherapy
<input type="checkbox"/>	<input type="checkbox"/>	Did your mother take DES when she was pregnant with you?

MUSCULOSKELETAL

<input type="checkbox"/>	<input type="checkbox"/>	Broken bones / fractures
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis or Osteoporosis

SKIN

<input type="checkbox"/>	<input type="checkbox"/>	Acne; other problems (specify)
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NEUROLOGICAL

<input type="checkbox"/>	<input type="checkbox"/>	Headaches / migraines: How often?
<input type="checkbox"/>	<input type="checkbox"/>	with visual changes
<input type="checkbox"/>	<input type="checkbox"/>	with numbness, tingling, weakness of arms / legs
<input type="checkbox"/>	<input type="checkbox"/>	Seizures / Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	See flashing / sparking lights with or without a headache

PSYCHOLOGICAL

<input type="checkbox"/>	<input type="checkbox"/>	Depression / Anxiety / Mood swings
<input type="checkbox"/>	<input type="checkbox"/>	Eating disorder (Anorexia / Bulimia)
<input type="checkbox"/>	<input type="checkbox"/>	Other

HEMATOLOGICAL/LYMPHATIC

<input type="checkbox"/>	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell disease / trait
<input type="checkbox"/>	<input type="checkbox"/>	Blood clotting disorder
<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusion
<input type="checkbox"/>	<input type="checkbox"/>	Frequent nose bleeds

ENDOCRINE

<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes

HOSPITALIZATIONS/SURGERY

<input type="checkbox"/>	<input type="checkbox"/>	Medical problems requiring hospitalization
<input type="checkbox"/>	<input type="checkbox"/>	Hospital stays other than childbirth or emergency room
<input type="checkbox"/>	<input type="checkbox"/>	Surgeries:

Name: _____

Chart #: _____ DOB: _____

Date: _____

