

COMPREHENSIVE MEDICAL HISTORY

Name _____ Date _____

Current Medications: _____
 Medication Allergies: _____ Reactions: _____

Medical History

Have You Had?	No	Yes	Date	Have You Had?	No	Yes	Date
Anorexia				Liver problem/disease (specify)			
Arthritis				Lung problem/disease (specify)			
Asthma				Mono			
Birth defects				Infertility			
Blood disorders/disease (specify)				History of Sexual or Physical Abuse			
Breast lump				Osteoporosis			
Cancer (specify)				Ovarian cysts/growths			
Chickenpox				Infection of uterus/tubes/ovaries			
Chlamydia				Psychiatric disorder (specify)			
Depression				Rheumatic fever			
Diabetes				Skin problems/disease (specify)			
Hard pain/cramps with periods				Stroke			
Ear problems/disease (specify)				Syphilis			
Epilepsy				Thyroid problems/disease (specify)			
Eye problem/disease (specify)				Tuberculosis			
Uterine growths/fibroids				Bladder infection			
Breast nipple discharge				Abnormal Pap smear			
Gastric ulcer				Other (specify)			
Genital warts							
Gonorrhea							
Hay fever/seasonal allergies							
Hepatitis (specify type)				Indicate whether you've had these tests and date of last one			
Do you ever miss a periods?				Pap smear			
Genital herpes				Mammogram			
Heart problem/disease (specify)				Colonoscopy			
High blood pressure				Bone density			
Kidney problem/disease (specify)				Thyroid			
Kidney infection				Cholesterol			

Surgical History

Date	List all previous hospitalizations, surgeries and procedures

Are you adopted? No Yes If yes, do you know your family history? No Yes

Family History

Has Any Blood Relative Ever Had?	No	Mat. Relative (specify)	Pat. Relative (specify)	Has Any Blood Relative Ever Had?	No	Mat. Relative (specify)	Pat. Relative (specify)
Arthritis				Goiter			
Asthma				Gout			
Birth Defect				Hay fever/allergies			
Blood disorder				Heart disease (specify)			
Breast cancer				Hepatitis (specify type)			
Cervical cancer				High blood pressure			
Ovarian cancer				Kidney disease (specify)			
Other cancer (specify)				Osteoporosis			
Birth defect				Stroke			
Diabetes				Thyroid disease			
Emphysema				Tuberculosis			
Endometriosis				Twins or Triplets			

Family Members

	Living	Health condition (poor/fair/good/excellent)	Deceased/Year/At what age
Father			
Mother			
Brother/Sister			
Brother/Sister			
Brother/Sister			
Brother/Sister			

Pregnancy History Have you ever been pregnant? **Yes No**

Please list all pregnancies

Delivery Date	Mo. Along	Vag or C-section	Complications	Living

Have you ever had a miscarriage or abortion? Yes No

Date	Wks. Along	Miscarriage	Abortion	Complications

Menstrual History

Age at first menstrual period _____

How often do you have periods? Every _____ days

How many days does period last? _____ days

Is your flow (circle one) Light Moderate Heavy

Bleeding/spotting between periods? No Yes

Pass clots with periods? No Yes

Current method of preventing pregnancy: (circle all that apply)

Abstinence (not sexually active) None (unprotected intercourse)
 Natural Family Planning Withdrawal Condoms Foam/Gel/Suppository
 Diaphragm Depo Provera IUD Oral Contraceptives
 Tubal Sterilization Partner Vasectomy Hysterectomy

Social History

Occupation _____

Substance Use

Caffeine never _____ times/day

Tobacco never _____ times/day

Alcohol never _____ times/week

Street drugs never _____ times/week

Education

Grade school _____ years

High school _____ years

College _____ years

Postgraduate _____ years

