

PATIENT PAST MEDICAL HISTORY

Name of Patient: _____ Date: _____

List any allergies to medication you may have: _____

List all medications you are currently taking: _____

Hospitalizations & approximate dates: _____

Surgery & approximate dates: _____

Normal Average Weight: _____ Do you smoke? Y/N If so, how much? _____

Contraception: _____ Date of Last Pap Smear: _____

Husband's Age: _____ If not living, cause of death and age at that time _____

Mother's Age: _____ If not living, cause of death and age at that time _____

Father's Age: _____ If not living, cause of death and age at that time _____

Have you ever had:

Abnormal Pap Smear	Y/N	Heart Trouble	Y/N	Cancer	Y/N
Herpes	Y/N	Heart Murmur	Y/N	Hepatitis	Y/N
Genital Warts	Y/N	High Blood Pressure	Y/N	Ulcer Symptoms	Y/N
Menopausal Symptoms	Y/N	Diabetes	Y/N	Rectal Bleeding	Y/N
Bladder Trouble	Y/N	Thyroid Trouble	Y/N	Hemorrhoids	Y/N
Kidney Trouble	Y/N	Epilepsy	Y/N	Asthma	Y/N
Anemia	Y/N	Other: _____			

Has any blood relative had any of the following diseases?

Heart Disease	Y/N	Tuberculosis	Y/N	Diabetes	Y/N
High Blood Pressure	Y/N	Cystic Fibrosis	Y/N		
Cancer	Y/N	Type of Cancer: _____			

Menstrual History:

Age at onset: _____ Interval: _____ days Duration: _____ days

First day of last period: _____ Cramps: MILD MODERATE SEVERE

Irregularities: _____ Medications for cramps: _____

Obstetrical History:

Total Pregnancies: _____ Full Term: _____ Premature: _____ Miscarriages: _____

Last Pregnancy (Month/Year): _____ Complications during pregnancy:

High Blood Pressure	Y/N	Toxemia	Y/N
Hemorrhoids	Y/N	Excessive Wt Gain	Y/N
Gestational Diabetes	Y/N	Anemia	Y/N

Other pertinent medical issues or concerns: _____