Medical History Today's Date: _____

Name: _____ DOB: _____ Male Female (Circle One)

Street Address: _____ City: _____ State: _____ Zip: _____

Home: (_____)_____-_____ Cell: (_____)_____-_____ Work: (_____)_____-_____ Ext: _____

Occupation: _____ (Circle One): Single Married Divorced Widowed Separated

If married, spouse's name: _____ ** Is your spouse your emergency contact? YES NO

Emergency Contact's Number: (_____)_____-_____ Name/Relationship: _____ **If other than spouse

Children's names and ages: _____

Do you have an Allergy to any of the following: Medications Latex Contrast/Dyes Bug Bites/Stings Foods Other (Circle all that apply)

If yes to ANY above, please list the name AND type of reaction: _____

(Circle) NKDA if you have No Know Drug Allergies _____

PAST MEDICAL HISTORY: (Please circle if you have had any problems with or experiencing any of the following):

High Blood Pressure	Persistent Cough	Unexplained weight gain/loss	Depression	Low Back Pain	Blood Disorders
Shortness of Breath	Pneumonia	Abdominal Discomfort	Anxiety	Head/Neck Pain	Hepatitis or Jaundice
Difficulty Breathing	Bronchitis	Gall Bladder Disease	Drug Abuse	Headaches	Venereal Diseases
Tightness/Pain in Chest	Tuberculosis	Constipation	Alcohol Abuse	Lightheadedness	Skin Disease
Palpitations	Indigestion	Diarrhea	Anemia	Swollen Ankles	Kidney Disease
Frequent Urination	Nausea	Colitis	Ulcers	Gout	Thyroid Disease
Rheumatic Fever	Vomiting	Blood in Stool	Hay Fever	Asthma	Change In Bowels
Cancer	Heart Disease	Hemorrhoids	Diabetes	Kidney Stones	Other:

_____

GYNECOLOGIC AND OBSTETRIC HISTORY:

Age at onset of periods: _____ Frequency: _____ Length of period: _____

Pregnancies: _____ Births: _____ Miscarriages: _____

Prolonged/abnormal bleeding: NO YES (Please describe) _____

Leakage of Urine: NO YES (Please describe) _____

Pelvic Pain or abnormal discharge: NO YES (Please describe) _____

Method of birth control: _____

Please List and supply the dates of:

Operations: _____

_____

Hospitalizations other than for surgery: _____

Immunization History (have you had the following):

Pneumovax?	NO	YES	When: _____
Tetanus?	NO	YES	When: _____
Hepatitis B?	NO	YES	When: _____
Influenza?	NO	YES	When: _____

I, _____ have been requested by Life Care Family Practice to supply ***my personal immunization records OR, if filling out this paperwork for a minor, the immunization records of my child. I understand that my immunization records are necessary to assist in keeping records up to date in order to receive the best medical care.

Signature _____ (Signature of patient OR legal guardian if patient is a minor)

When was your last Pap Smear: _____ Breast Exam: _____ Mammogram: _____

Cholesterol Check: _____ Prostate Exam: _____ Stool checked for blood: _____

FAMILY HISTORY: Has any member of your family (including parents, grandparents, and siblings) ever had the following?

Illness	Which Family Member(s)	Approx. age when diagnosed
Cancer (what kind):	_____	_____
Hypertension (high blood pressure):	_____	_____
Heart Disease:	_____	_____
Diabetes:	_____	_____
Mental Disease (Anxiety, depression, etc.)	_____	_____
Drug or Alcohol Addiction:	_____	_____
Glaucoma:	_____	_____
Bleeding Disease:	_____	_____
Other:	_____	_____

MEDICATIONS (Prescription, over the counter, vitamins, herbs, etc.):

Drug Name: _____	Strength: _____	Drug Name: _____	Strength: _____
Drug Name: _____	Strength: _____	Drug Name: _____	Strength: _____
Drug Name: _____	Strength: _____	Drug Name: _____	Strength: _____
Drug Name: _____	Strength: _____	Drug Name: _____	Strength: _____

Pharmacy Name: _____ Location: _____ Pharmacy Phone: _____

PREVENTION

Do you smoke?	NO	YES	If yes, how many packs per day? _____		
Do you drink alcoholic beverages?	NO	YES	If yes, how much per week? _____		
Do you drink coffee or tea?	NO	YES	If yes, how many cups per day? _____		
Do you use recreational drugs?	NO	YES	If yes, explain which one(s) & how often: _____		
Do you have a living will?	NO	YES	Do you wish to be tested for AIDS?	NO	YES

Have you ever worked with chemicals, paints, asbestos, or other hazardous material? NO YES