(Confidential)

Patient Name_____ Today's Date_____

Age_____ Birth Date_____ Marital Status S-M-W-D-Sep Date of last exam_____

What is your reason for visit? _____

Optional: e-mail address _____

Symptoms

Check (√) symptoms you currently have or have had in the past year.

GENERAL

□ Chills
□ Depression
□ Dizziness
□ Fainting
□ Fever
□ Forgetfulness
□ Headache
□ Leg Cramps
□ Loss of sleep
□ Loss of weight
□ Nervousness
□ Numbness
□ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

□ Arms □ Hips
□ Back □ Legs
□ Feet □ Neck
□ Hands □ Shoulders

GENITOURINARY

□ Blood in urine
□ Frequent urination
□ Lack of bladder control
□ Painful urination
□ Increased thirst

GASTROINTESTINAL

□ Appetite poor
□ Black stools
□ Bloating
□ Bowel changes
□ Constipation
□ Diarrhea
□ Excessive hunger
□ Excessive thirst
□ Gas
□ Hemorrhoids
□ Indigestion
□ Nausea
□ Rectal bleeding
□ Stomach pain
□ Vomiting
□ Vomited or coughed blood

CARDIOVASCULAR

□ Chest pain
□ Difficult to breath
□ High blood pressure
□ Irregular heart beat
□ Low blood pressure
□ Poor circulation
□ Rapid heart beat
□ Swelling of ankles, hands, feet
□ Varicose or enlarged veins

EYE, EAR, NOSE, THROAT

□ Bleeding gums
□ Difficulty swallowing
□ Ear pain or discharge
□ Hoarseness
□ Loss of hearing
□ Nosebleeds
□ Persistent cough
□ Ringing in ears
□ Sinus problems
□ Vision problems
□ Wear glasses or contacts

SKIN

□ Bruise easily
□ Hives
□ Itching
□ Change in moles
□ Rash
□ Scars
□ Sore that won't heal

WOMEN

Circle one or complete each line.

Are you Pregnant? Yes/No/Not Sure
Date of Last PAP_____
Abnormal PAP smear? Yes / No
Date_____
How often do you do self breast exams? _____
Breast lump? Yes / No
Nipple discharge? Yes / No
Date of Last Mammogram_____
Hot flashes? Yes / No
Lack of sex drive? Yes / No
Vaginal dryness? Yes / No
Vaginal discharge? Yes / No
Pain with intercourse? Yes / No
Menstrual History:
Age period began_____
Bleeding between periods? Yes / No
Menstrual pain/cramps? Yes / No
Rate your pain on scale 1-10 (#10 Is worst) Rate of pain # _____
Date of Last Period _____
Days between periods_____
Days your period lasts_____
Pregnancies _____
Babies born alive _____
Still born_____
Full term_____
Premature_____
Miscarriages_____
Ectopic pregnancies_____
Multiple births_____
Complications with any of your Pregnancies (please explain):

_____

_____

_____

Conditions

Check (√) conditions you currently have or have had in the past year.

□ AIDS
□ Alcoholism
□ Anemia
□ Anorexia
□ Appendicitis
□ Arthritis
□ Asthma
□ Bleeding Disorders
□ Breast Lump
□ Bronchitis
□ Bulimia
□ Cancer
□ Cataracts
□ Chemical Dependency
□ Chicken Pox
□ Diabetes
□ Emphysema
□ Epilepsy
□ Endometriosis
□ Glaucoma
□ Goiter
□ Gonorrhea
□ Gout
□ Heart Disease
□ Hepatitis
□ Hernia
□ Herpes
□ High Cholesterol
□ HIV Positive
□ Kidney Disease
□ Liver Disease
□ Measles
□ Migraine Headaches
□ Miscarriage
□ Mononucleosis
□ Multiple Sclerosis
□ Mumps
□ Pacemaker
□ Pneumonia
□ Polio
□ Psychiatric Care
□ Rheumatic Fever
□ Seizure disorder
□ Stroke
□ Suicide Attempt
□ Thyroid Problems
□ Tonsillitis
□ Tuberculosis
□ Ulcers
□ Vaginal Infections
□ Venereal Disease

Allergies

(food, medications, environment)

_____
_____
_____
_____
_____

Midwest OB/GYN Health History

Side 1

(OVER)

Family History

Fill in health information about your family.

Relation	Present Age	Age at Death	State of Health or Cause of Death		Check (√) if, your blood relatives had any of the following: Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Cancer	
Siblings					Chemical Dependency	
					Diabetes	
Children					Heart Disease	
					High Blood Pressure	
Maternal grandmother					Kidney Disease	
Maternal grandfather					Stroke	
Paternal grandmother					Tuberculosis	
Paternal grandfather					Other	

Hospitalizations / Surgery / Illness / Injury

Date	Explain	Treatment (hospital or doctor)

Medications

List medications you are currently taking.

_____

_____

_____

_____

_____

_____

_____

Health Habits / Misc.

Yes	No		Type & Amount
		Alcohol	
		Caffeine	
		Calcium	
		Exercise	
		Street Drugs	
		Tobacco	
		Seat Belts	
		Stress at Work	
		Heavy Lifting	
		Exposed to Hazardous Substances	
		Domestic Violence	

Average # of hours of sleep per night? _____

Have you ever had a blood transfusion? □ No

□ Yes If yes, date:_____

Pharmacy you use

Name: _____

Town located in: _____

I certify that the above information is correct to the best of my knowledge. I will not hold any provider or any members of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

_____ _____

Patient Signature Date