Medical History Form

Date Completed:	Name:	Date of birth:
Address:		

City:	State	Zip:

Daytime phone:	Evening Phone:
Fax:	Email:

Sex: ☐ Male ☐ Female

Marital status: ☐ Married ☐ Single ☐ Divorced/Separated/Widowed ☐ Other:_____________

Primary Language: ☐ English ☐ Spanish ☐ Other: ____________ Translator needed : ☐ Yes ☐ No

Ethnic background: ☐ Caucasian ☐ Black/African American ☐ Hispanic ☐ Native American ☐ Arab/Middle Eastern ☐ Asian/Pacific Islander ☐ Jewish ancestry ☐ Other ____________

Educational background: ______________________Occupation: ________________________________

Referring Physician
Name:
Address:
Phone:

Past Medical History: Please check all previous or current illnesses

☐ Heart problems ☐ Seizures ☐ Bleeding problems ☐ High blood pressure ☐ Thyroid problems
☐ Lung problems ☐ Diabetes ☐ Circulation problems ☐ Liver problems ☐ Stroke
☐ Kidney/Urine Problems ☐ Gastrointestinal/Bowel problems ☐ HIV/AIDS ☐ Vision/Hearing
☐ Bone or skeletal problems ☐ Problems with the development of teeth, or extra or missing teeth
☐ Environmental exposures (ex: radiation, chemical exposures)____

Please provide a description of your past illnesses for the boxes you checked above (you may use the back if necessary):

Past Surgical History: (include the type of surgery and date):

Cancer History:

Have you been diagnosed with cancer? ☐ Yes ☐ No

Diagnosis:__________________ Age:_____ Treatment:______________________________ At what institution was this cancer treated?	Second cancer:____________________Age:_____ Treatment:______________________________ At what institution was this cancer treated?
Other Cancers:	

Past Urologic History (Males Only):

Have you begun prostate cancer screening? ☐ Yes ☐ No

When was your last PSA blood test? ___________ When was your last prostate examination?______

Have you ever had an abnormally high PSA level? _____________________________________

Past OB/Gyn History (Females Only):

Age periods started: __________ Last menstrual period:________

Age at first birth: ______Number of births: _______ Number of miscarriages or still births: ______

Any history of infertility?: ☐ Yes ☐ No

Are you currently using oral contraceptives?: ☐ Yes ☐ No

Have you used oral contraceptives in the past?: ☐ Yes ☐ No

What is the total amount of time you used these medications? Years_____ Months________

Please list other hormonal methods of birth control you have used:______________________

Last Pap smear: __________________

Any abnormal Pap smears? ☐ Yes ☐ No When? ____________________________________

Have you had a hysterectomy?: ☐ Yes ☐ No At what age? _____

Were your ovaries removed? ☐ Yes ☐ No

Age at menopause: ____________

Are you currently using hormone replacement therapy?: ☐ Yes ☐ No

Have you ever used hormone replacement therapy in the past? ☐ Yes ☐ No

What is the total amount of time you used these medications? Years_____Months_______

Have you used any natural or herbal products to deal with symptoms of menopause? ☐ Yes ☐ No

If yes, what products have you used? ____

Do you perform self breast exams? ☐ Yes ☐ NO

Age at first mammogram: ____ Last mammogram: __________Number of past breast biopsies______

Have you had any screening for ovarian cancer? ☐ Yes ☐ No (If yes, please answer the following questions.)

Have you had a CA-125 blood test?: ☐ Yes ☐ No Date of most recent test: ______________

Have you had a transvaginal ultrasound?: ☐ Yes ☐ No Date of most recent scan: __________

Have you had screening for endometrial (lining of the uterus) cancer? ☐ Yes ☐ No (If yes, please answer the following questions.)

Have you had a transvaginal ultrasound? ☐ Yes ☐ No Date of most recent scan: ___________

Have you had an endometrial biopsy? ☐ Yes ☐ No Date of most recent biopsy:____________

Have you had abnormal cells detected on biopsy? ____________________________

Other Cancer Screening History:

Colon

Have you ever had a colon examination? ☐ Yes ☐ No

When was your last colon examination?: __________

Method of exam: ☐ Colonoscopy ☐ Flexible sigmoidoscopy ☐ Barium enema ☐ Stool blood test

Do you have any history of colon polyps?: ☐ Yes ☐ No

If yes: approximate number of polyps:___________ Years detected:_________________

Type of polyps if known:____

Skin

Have you had any precancerous moles removed? ☐ Yes ☐ No

If yes: approximate number removed:_________________ Years detected:__________________

Current Medications (use back if necessary)**:**

Name of Medication	Dose	How Often Taken	Reason for Taking

Allergies

Please list any medications, food products, or other things to which you are allergic:

Social History

Do you currently use tobacco? ☐ Yes ☐ No

If yes, which types? ☐ Cigarettes Amount/Day___________ Years used _______________

☐ Cigars Amount/Day___________ Years used _______________

☐ Chew tobacco/snuff Amount/Day __________ Years used_____________

Have you used tobacco in the past, but have now quit? ☐ Yes ☐ No

When did you quit? _________________________

What types of tobacco did you use?

☐ Cigarettes Amount/Day___________ Years used _______________

☐ Cigars Amount/Day___________ Years used ______________

☐ Chew tobacco/snuff Amount/Day __________ Years used_______________

Do you use street drugs? ☐ Yes ☐ No Type: _____________________Quit: _______________

Do you drink alcohol? ☐ Yes ☐ No Number of Drinks/week____________________________

Genetic History

Have you been diagnosed with a genetic condition? ☐ Yes ☐ No

Please list your diagnosis: ____

Have you had a genetic test? ☐ Yes ☐ No

For what condition?____

What was the result? ____