

Medical History Form



Please complete this form

Today's date _____

Appointment date _____

Name: _____
(First) (Middle) (Last)

Date of Birth: _____

Pharmacy: _____
(Name) (Location) (Fax Number) (Ph Number)

Primary Care Physician: _____

- Mail form in the enclosed envelope (1 week prior to your appointment) **OR**
- Fax to Burnsville 952-435-6205 Edina 952-920-2245 **OR**
- Bring to your appointment. If you do not mail or fax the form, you **MUST ARRIVE 30 minutes** prior to your appointment time, **or your appointment may be rescheduled.**

What are your primary concerns today? _____ Is this a new problem? Yes No

If you have had any of the following medical problems in the past, please indicate by checking box.

Past Medical History			
<p style="text-align: center;">Gynecologic</p> <input type="checkbox"/> Abnormal pap smear <input type="checkbox"/> DES Exposure <input type="checkbox"/> Endometriosis <input type="checkbox"/> Fibroids (Uterine Fibroids) <input type="checkbox"/> Ovarian Cysts that required surgery <input type="checkbox"/> Sexually transmitted diseases (STDs) Type _____ <input type="checkbox"/> Other: _____ <p style="text-align: center;">Breast</p> <input type="checkbox"/> Breast Cancer <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> <input type="checkbox"/> Breast Implants <input type="checkbox"/> Breast lumps – Requiring Surgery Surgery Type _____ <input type="checkbox"/> Other: _____ <p style="text-align: center;">Cardiovascular</p> <input type="checkbox"/> Heart attack <input type="checkbox"/> High cholesterol <input type="checkbox"/> Hypertension (high blood pressure) <input type="checkbox"/> Mitral valve prolapse/murmur <input type="checkbox"/> Other: _____ <p style="text-align: center;">Digestive</p> <input type="checkbox"/> Colitis/Crohns/IBS (Circle One) <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Hepatitis <input type="checkbox"/> Reflux disease (GERD) <input type="checkbox"/> Stomach ulcer <input type="checkbox"/> Other: _____ <p style="text-align: center;">Endocrine</p> <input type="checkbox"/> Autoimmune disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid problems <input type="checkbox"/> Other: _____ <p style="text-align: center;">Hematologic</p> <input type="checkbox"/> Anemia <input type="checkbox"/> Blood clotting disorders <input type="checkbox"/> Sickle cell <input type="checkbox"/> Other: _____	<p style="text-align: center;">Injury/Poisonings</p> <input type="checkbox"/> Fractures Date _____ Description _____ <input type="checkbox"/> Motor vehicle accident Requiring Hospitalization? <input type="checkbox"/> Date _____ <input type="checkbox"/> Other (injury/poisonings): _____ <p style="text-align: center;">Musculoskeletal</p> <input type="checkbox"/> Arthritis <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Systemic lupus <input type="checkbox"/> Other: _____ <p style="text-align: center;">Cancer of...</p> <input type="checkbox"/> Colon <input type="checkbox"/> Ovary <input type="checkbox"/> Skin <input type="checkbox"/> Uterus <input type="checkbox"/> Other: _____ <p style="text-align: center;">Neurologic</p> <input type="checkbox"/> Migraines <input type="checkbox"/> Seizures <input type="checkbox"/> Strokes <input type="checkbox"/> Other: _____ <p style="text-align: center;">Psychiatric</p> <input type="checkbox"/> Anxiety disorder <input type="checkbox"/> Depression <input type="checkbox"/> Post Partum Depression <input type="checkbox"/> Other: _____ <p style="text-align: center;">Respiratory</p> <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema COPD <input type="checkbox"/> Other: _____ <p style="text-align: center;">Urologic</p> <input type="checkbox"/> Frequent urinary infections <input type="checkbox"/> Incontinence <input type="checkbox"/> Kidney stones <input type="checkbox"/> Other: _____		
Other: _____			
Date of Last Pap Smear: _____ Normal Abnormal		Date of Last Mammogram: _____ Normal Abnormal	
Date of Last Bone Density Scan: _____ Normal Abnormal		Date of Last Colonoscopy: _____ Normal Abnormal	
Date of Last Cholesterol Screen: _____ Normal Abnormal			

Please list (below) any prior surgeries you have had, including wisdom teeth removal, tonsillectomy, appendectomy, etc.

Surgery/Reason	Date	Surgery/Reason (cont'd)	Date

CURRENT MEDICATIONS: (List all medications, even over the counter, vitamins, herbal remedies, etc. Include the following information regarding your medications You may use additional pages if necessary. Also, please bring all your medications with you to your appointment.)

Medication	Strength	How Often	Prescribed By	Reason

Please list known allergies and reactions to medications or substances (e.g., latex, iodine, etc.)

<input type="checkbox"/> No Known Allergies		Allergy	Reaction
Allergy	Reaction	Allergy	Reaction
Allergy	Reaction	Allergy	Reaction
Allergy	Reaction	Allergy	Reaction

FAMILY HISTORY: (Please check if any of your family members have had the following)

Adopted? Yes No

ILLNESS	Mother	Father	Brother	Sister	Mom's Mother	Dad's Mother	Mom's Father	Dad's Father	Aunt	Uncle	Age of Onset
Blood clot in leg / lungs (circle one)											
Cancer, Breast											
Cancer, Colon											
Cancer, Ovarian											
Cancer, Uterine											
Cancer, Other (write below)											
Cardiovascular Disease											
Depression											
Diabetes											
Hypertension											
Osteoporosis											
Polyp - anal/rectal/colon											
Stroke											
Thyroid Disorder											
High Cholesterol											

Reproductive History

Age of first menses (period):	Cycle Interval (Number of days from start to start):
Menses duration (Number of days of bleeding):	Flow (Light, Medium, or Heavy):
Number of Tampons/day:	Number of Pads/day:
Last Menstrual Period: / / (Date)	Certain of Last Menstrual Period Date (yes or no)?
Menopause Status (Pre, Peri or Post):	Age at Menopause:
Method of Birth Control:	Clots (yes or no)?
Bleeding between periods (yes or no):	On Hormone Replacements (yes or no)?

Prenatal Summary

Total # of Pregnancies	Ectopic or Tubal Pregnancies
Living Children	Miscarriages
Full Term Births	Abortions, Induced
Premature Births	

Pregnancy Details (if child bearing age)

Birth Date	Gestational Weeks	Hours in Labor	Baby's Weight	Baby's Sex	Type of Delivery	Anesthesia	Any Preterm Labor?	Complications	Child's Name	Hospital

Social History

Marital Status <input type="checkbox"/> Dating <input type="checkbox"/> Divorced <input type="checkbox"/> Engaged <input type="checkbox"/> Married <input type="checkbox"/> Not Dating <input type="checkbox"/> Single <input type="checkbox"/> Widowed
Spouse/Partner Name: _____ Your Occupation: _____
Alcohol: <input type="checkbox"/> Never <input type="checkbox"/> Current <input type="checkbox"/> Former Amount per Week: _____
Caffeine <input type="checkbox"/> Never <input type="checkbox"/> Current <input type="checkbox"/> Former Amount per Day: _____
Drugs: <input type="checkbox"/> Never <input type="checkbox"/> Current <input type="checkbox"/> Former Type: _____
Smoking: <input type="checkbox"/> Never <input type="checkbox"/> Current <input type="checkbox"/> Former Amount per Day: _____
Exercise: <input type="checkbox"/> None (Sedentary) <input type="checkbox"/> Minimal (once/week or less) <input type="checkbox"/> Moderate (1-3 times/week) <input type="checkbox"/> Heavy (4 or more times/week)
Have you been sexually, physically, emotionally abused, threatened or hurt by anyone? <input type="checkbox"/> Yes <input type="checkbox"/> No