

## Patient Medical History-1

<b>Demographics</b>	Name: _____ S.S. #: _____ Date of Birth: _____ Age: _____				
<b>Obstetrical History</b>	Total Number of Pregnancies: _____		Total Number of Living Children: _____		Miscarriages: _____
	Name of Child	(sex)	Health	Year Born & Weight	M.D./CNM
		( )			
		( )			
		( )			
		( )			
<b>Menstrual History</b>	Last Period: _____		Cycle Length? _____	Days	Flow: Regular/Irregular
	Cramps?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Amount of Flow: <input type="checkbox"/> Light <input type="checkbox"/> Medium <input type="checkbox"/> Heavy <input type="checkbox"/> Clots	
	Pain Meds?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Name of medication _____	When? Before / During / After bleed	
	Menopause	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<b>Birth Control:</b> _____	
<b>Cancer Screen</b>	Self Breast Exam: _____		Last Pap Date: _____	Last Mammogram Date: _____	
<b>Illness/Surgery Excluding Childhood</b>	Year:	Type of Illness or Surgery:		Hospital	M.D.
	_____	_____		_____	_____
	_____	_____		_____	_____
	_____	_____		_____	_____
	_____	_____		_____	_____
<b>Allergies</b>	Known Drug Allergies?		<input type="checkbox"/> No	<input type="checkbox"/> Yes, if so, which ones	
	Known Latex Allergy?		<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Don't Know
<b>Medications O-T-C Drugs Special Health Foods</b>	Name	Dose/Frequency		Reason	
	_____	_____		_____	
	_____	_____		_____	
	_____	_____		_____	
	_____	_____		_____	

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Patient Medical History-2

<b>Dr/NP/PA Review</b>	Date: _____ By: _____ Comment: _____ _____ _____ _____																		
<b>Family History</b>	<p style="margin-left: 20px;"> </p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;">Who</th> <th style="width: 50%;">Disease</th> <th style="width: 25%;">Status</th> </tr> </thead> <tbody> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> </tbody> </table>			Who	Disease	Status	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	
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_____	_____	_____																	
_____	_____	_____																	
_____	_____	_____																	
_____	_____	_____																	
<b>Social History</b>	Marital Status: _____ Smoking <input type="checkbox"/> Yes <input type="checkbox"/> No    Packs/day _____ # yrs _____ Type of Work Done: _____ Alcohol <input type="checkbox"/> Yes <input type="checkbox"/> No    Drinks/Day _____ week _____ Use Seat Belt <input type="checkbox"/> Yes <input type="checkbox"/> No    Street Drugs <input type="checkbox"/> Yes <input type="checkbox"/> No    Type: _____ Regular Exercise <input type="checkbox"/> Yes <input type="checkbox"/> No    Frequency: _____																		
<b>Review of Systems</b>	<p style="text-align: center;">Have you had any of these problems? Answer each item with a Yes (Y) or a No (N)</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 25%; vertical-align: top;"> <b>Constitutional</b>            Y N Fatigue            Y N Weight Change            Y N Fever/Chills             Other: _____         </td> <td style="width: 25%; vertical-align: top;"> <b>Neurological</b>            Y N Tremors            Y N Dizziness            Y N Numbness/Tingling             Other: _____         </td> <td style="width: 25%; vertical-align: top;"> <b>Hematologic/Lymphatic</b>            Y N Swollen Glands            Y N Bleeding Problems            Y N Anemia             Other: _____         </td> <td style="width: 25%; vertical-align: top;"> <b>Eyes</b>            Y N Blurred Vision            Y N Pain             Other: _____         </td> </tr> <tr> <td style="vertical-align: top;"> <b>Ears, Nose, Throat, Mouth</b>            Y N Ear Infection            Y N Hearing Problem            Y N Sinus            Y N Sore Throat             Other: _____         </td> <td style="vertical-align: top;"> <b>Psychiatric</b>            Y N Anxiety            Y N Depression            Y N Considered Suicide            Y N Eating Disorder             Other: _____         </td> <td style="vertical-align: top;"> <b>Endocrine</b>            Y N Appetite Change            Y N Excessive Thirst            Y N Fatigue/Sluggish            Y N Too Hot/Cold             Other: _____         </td> <td style="vertical-align: top;"> <b>Integumentary</b>            Y N Rash/Itch            Y N Change in Mole/Lesion            Y N Breast lump/discharge            Y N Breast Pain             Other: _____         </td> </tr> <tr> <td style="vertical-align: top;"> <b>Cardiovascular</b>            Y N Chest Pain            Y N Varicose Veins            Y N Shortness of Breath            Y N High Blood Pressure             Other: _____         </td> <td style="vertical-align: top;"> <b>Respiratory</b>            Y N Wheezing            Y N Coughing            Y N Shortness of Breath             Other: _____         </td> <td style="vertical-align: top;"> <b>Allergies/Immunizations</b>            Y N Hay Fever            Y N Drug Allergies            Y N Latex Allergies             Other: _____         </td> <td style="vertical-align: top;"> <b>Gastrointestinal</b>            Y N Abdominal Pain            Y N Nausea/Vomiting            Y N Indigestion/Heartburn            Y N Blood/Change in Stool             Other: _____         </td> </tr> <tr> <td style="vertical-align: top;"> <b>Musculoskeletal</b>            Y N Joint Pain            Y N Neck Pain            Y N Back Pain            Y N Osteoporosis             Other: _____         </td> <td style="vertical-align: top;"> <b>Genitourinary</b>            Y N Painful Urination            Y N Urinary Frequency            Y N Urinary Incontinence            Y N Prolapse Bladder             Other: _____         </td> <td style="vertical-align: top;"> <b>Sexual Problems</b>            Y N Abuse            Y N Sex Drive            Y N History of STD's             Other: _____         </td> <td style="vertical-align: top;">           Except for the problems circled Y, all other systems are negative             Dr/NP/PA _____         </td> </tr> </table>			<b>Constitutional</b> Y N Fatigue Y N Weight Change Y N Fever/Chills  Other: _____	<b>Neurological</b> Y N Tremors Y N Dizziness Y N Numbness/Tingling  Other: _____	<b>Hematologic/Lymphatic</b> Y N Swollen Glands Y N Bleeding Problems Y N Anemia  Other: _____	<b>Eyes</b> Y N Blurred Vision Y N Pain  Other: _____	<b>Ears, Nose, Throat, Mouth</b> Y N Ear Infection Y N Hearing Problem Y N Sinus Y N Sore Throat  Other: _____	<b>Psychiatric</b> Y N Anxiety Y N Depression Y N Considered Suicide Y N Eating Disorder  Other: _____	<b>Endocrine</b> Y N Appetite Change Y N Excessive Thirst Y N Fatigue/Sluggish Y N Too Hot/Cold  Other: _____	<b>Integumentary</b> Y N Rash/Itch Y N Change in Mole/Lesion Y N Breast lump/discharge Y N Breast Pain  Other: _____	<b>Cardiovascular</b> Y N Chest Pain Y N Varicose Veins Y N Shortness of Breath Y N High Blood Pressure  Other: _____	<b>Respiratory</b> Y N Wheezing Y N Coughing Y N Shortness of Breath  Other: _____	<b>Allergies/Immunizations</b> Y N Hay Fever Y N Drug Allergies Y N Latex Allergies  Other: _____	<b>Gastrointestinal</b> Y N Abdominal Pain Y N Nausea/Vomiting Y N Indigestion/Heartburn Y N Blood/Change in Stool  Other: _____	<b>Musculoskeletal</b> Y N Joint Pain Y N Neck Pain Y N Back Pain Y N Osteoporosis  Other: _____	<b>Genitourinary</b> Y N Painful Urination Y N Urinary Frequency Y N Urinary Incontinence Y N Prolapse Bladder  Other: _____	<b>Sexual Problems</b> Y N Abuse Y N Sex Drive Y N History of STD's  Other: _____	Except for the problems circled Y, all other systems are negative  Dr/NP/PA _____
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<b>Sign</b>	I authorize Village Obstetrics to release information to my insurance carriers regarding my medical care.  Signature _____ Date _____																		