MEDICAL HISTORY page 1 of 3

NAME: _____RECORD #: _____

Allergy to...	Reaction

VACCINATIONS

☐Influenza	When:	☐Human Papillomavirus:	When:
☐Measles, Mumps, Rubella	When:	☐Hepatitis A B (circle)	When:
☐Zoster	When:	☐other	When:
☐Tetanus, Diptheria, Pertussis	When:	☐other	When:
		☐other	When:

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Alcoholism	☐		
Asthma	☐		
Cancer, type:	☐		
Depression/Anxiety/Bipolar	☐		
Diabetes, type:	☐		
Emphysema (COPD)	☐		
Heart Disease	☐		
High Blood Pressure (hypertension)	☐		
High Cholesterol	☐		
Illicit Drug Use, type:	☐		
Thyroid Disease, type:	☐		
Renal/Kidney Disease	☐		
Migraine / Headaches	☐		
Stroke	☐		
Other:	☐		
Other:	☐		
Other:	☐		

MEDICAL HISTORY page 2 of 3 Name: _____

SURGERIES	WHEN	PERFORMED AT / BY

WOMEN'S HEALTH

Age of first menstrual cycle:	Age of last menstrual cycle:
Menstrual cycles are now: ☐Regular ☐Irregular ☐Stopped (since):	
Total number of pregnancies:	Total number of live births:
Pregnancy Complications:	

MEN'S HEALTH

Age of first Prostate exam:	Latest PSA Test: When: _____Result: _____
History of Erectile dysfunction: ☐None ☐Current ☐Past (when):	

Recreational Drug Use

Tobacco consumption: ☐ None ☐ Cigarettes ☐ Cigar/Pipes ☐ Vaping ☐ Chew	
Started when:	Stopped when:
Average consumption was/is: # packs/day _____ for _____ # years	
Alcohol consumption: ☐ None ☐ Beer ☐ Wine ☐ Liquor	Drinks Per week: # _____
Do you use Marijuana products: ☐ No ☐ Yes (how often)? _____	
Have you ever used Needles to inject a drug? ☐ Yes ☐ No	Have you ever been Hospitalized for overdose?☐Yes ☐No

MEDICAL HISTORY page 3 of 3 Name: _____

GENDER IDENTITY & SEXUAL ACTIVITY

Sexual Activity: ☐ Never ☐ single partner ☐ multiple partners (☐in past ☐ presently)

Sexual partners: ☐ Male ☐ Female ☐ Other: _____

Birth control method: ☐ None ☐ Condom ☐ Other: _____ ☐ Vasectomy

Gender identity: ☐ Male ☐ Female ☐Other: _____

Reproductive system consistent with: ☐ Male ☐Female

SLEEP, DIET & EXERCISE

Average amount of Sleep per 24 hours: _____ # of hours	How would you rate your sleep? ☐ intermittent ☐poor quality ☐fine
How would you rate your diet? ☐ Good ☐ Fair ☐Poor	☐ Vegan / Vegetarian
Do you exercise regularly? ☐Yes ☐No	Exercise Duration: _____ (min) How Often: _____

FAMILY MEDICAL HISTORY

Check all That apply	alcoholism	Asthma	Cancer. type	Depression, Anxiety, bipolar	Diabetes, type	Emphysema (COPD)	Heart Disease	High blood pressure	High cholesterol	Kidney disease	Migraine/ headache	Stroke	Thyroid disease. Type	Other	Other	Early death
Mother																
Father																
Sibling: m/f																
Sibling: m/f																
Sibling: m/f																
Maternal Grandmother																
Maternal Grandfather																
Paternal Grandmother																
Paternal Grandfather																
Other																

NOTES:

_____

_____