Abington Health Physicians

PATIENT MEDICAL HISTORY FORM

Name: _____ **Date:** ____/____/____

Occupation: _____ **Birthdate:** ____/____/____ **Age:** _____ **Gender:** ☐ Male ☐ Female

Allergies to Medications, X-ray Dyes or other Substances: ☐ None

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Current Medications, Vitamins, Supplements, Herbs - Prescription and Over-the-Counter: ☐ None ***** List Name and Dose *****

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Past Medical History and Review of Symptoms

☐ High Blood Pressure	☐ Bronchitis	☐ Change in bowel habits	☐ Arthritis
☐ Diabetes	☐ Pneumonia	☐ Unexplained weight loss/gain	☐ Osteoporosis
☐ Cancer	☐ Persistent cough	☐ Hemorrhoids	☐ Low back problems
☐ Anemia	☐ T.B.	☐ Gall bladder disease	☐ Numbness of arms or legs
☐ Heart Disease	☐ Hay fever	☐ Colitis	☐ Skin diseases
☐ Chest Pain or tightness	☐ Abdominal discomfort	☐ Bruise easily	☐ Blood disorders
☐ Shortness of Breath	☐ Indigestion	☐ Thyroid Disease	☐ Sexually Transmitted Disease
☐ Swollen ankles	☐ Nausea / Vomiting	☐ Head or neck radiation	☐ Anxiety
☐ Palpitations	☐ Diarrhea	☐ Headache	☐ Depression
☐ Lightheadness	☐ Constipation	☐ Kidney disease	☐ Alcohol abuse
☐ Frequent urination	☐ Blood in stool	☐ Kidney stones	☐ Drug abuse
☐ Rheumatic Fever	☐ Ulcers	☐ Difficulty passing urine	☐ Gout
☐ Asthma	☐ Hepatitis	☐ Difficulty holding urine	☐ Sleep Problems

_____ _____ _____ _____

Gynecologic and Obstetric History: Women only

Age at onset of periods: _____ Frequency: _____ Length of Period: _____

Pregnancies: _____ Births: _____ Miscarriages: _____

Prolonged or abnormal bleeding? ☐ No ☐ Yes (Please describe) _____

Leakage of urine? ☐ No ☐ Yes (Please describe) _____

Pelvic Pain? ☐ No ☐ Yes (Please describe) _____

Abnormal Discharge? ☐ No ☐ Yes (Please describe) _____

History of abnormal Pap smear? ☐ No ☐ Yes (Please describe) _____

Abington Health Physicians

PATIENT MEDICAL HISTORY FORM

Name: _____ **Date:** ____/_____/_____

Operations & Hospitalizations (List Year and type of operation or diagnoses after hospitalization)

_____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____

Immunization History	Year	Other Vaccines	Year
Last Tetanus Shot?		Lyme Vaccine?	
Pneumovax Shot?		Hepatitis A Vaccine?	
Flu Shot?			
Hepatitis B Vaccine?			

Screening Tests (Last One)	Year
Mammogram?	
Breast Exam?	
Pap Smear?	
Cholesterol Check?	
Stool Check for blood?	
Prostate Exam?	

Family History

Illness	GF	GM	F	M	Br	Sis	Child		Age(s) when Diagnosed
Cancer (type):									
Hypertension									
Diabetes									
Strokes									
Mental Disease (anxiety, depression)									
Drug or Alcohol addiction									
Glaucoma									
Bleeding Diseases									
Other:									

Prevention:

Do you wear seat belts?	☐ Yes	☐ No	Women: Do you perform self breast exams?	☐ Yes	☐ No
Do you wear a bike helmet?	☐ Yes	☐ No	Men: Do you perform self testicular exams?	☐ Yes	☐ No
Do you smoke? Amount:	☐ Yes	☐ No	Do you exercise regularly?	☐ Yes	☐ No
Do you drink alcohol beverages?	☐ Yes	☐ No	Are you following a specific diet?	☐ Yes	☐ No
Do you drink coffee? Amount:	☐ Yes	☐ No	If so, type of diet:		
Do you drink tea?	☐ Yes	☐ No	Do you ever feel afraid of your partner?	☐ Yes	☐ No
Is there a gun in your home?	☐ Yes	☐ No	Do you have a living will?	☐ Yes	☐ No
Do you use drugs? Type:	☐ Yes	☐ No	Do you have a donor card?	☐ Yes	☐ No
Have you ever engaged in any activity which would put you at risk of AIDS?	☐ Yes	☐ No	Have you ever worked with chemicals, paints, asbestos or other hazardous material?	☐ Yes	☐ No