THE WOMEN & CHILDREN'S NATURAL HEALTH CENTER

ADULT MEDICAL HISTORY

Date _____

Name _____ Age _____ Birthdate _____

Address _____ Sex ☐ Male ☐ Female

_____ Home Phone _____

_____ Work Phone _____

Occupation _____ Emergency Contact _____

☐ Single ☐Married ☐Widowed ☐Separated ☐Divorced Phone _____

If married, spouse's name _____

Children's names and ages _____

Allergies to Medications, X-Ray Dyes, or Other Substances ☐ No ☐ Yes

(If yes, please list name of medicine and type of reaction)

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Past Medical

Please check off if you have had any problems with or are presently experiencing any of the following:

☐ High Blood Pressure	☐ Bronchitis	☐ Change in bowel habits	☐ Arthritis
☐ Diabetes	☐ Pneumonia	☐ Unexplained weight gain/loss	☐ Low back problems
☐ Cancer	☐ Persistent cough	☐ Hemorrhoids	☐ Skin diseases
☐ Heart Disease	☐ T.B.	☐ Gall Bladder disease	☐ Blood disorders
☐ Chest pain/ chest tightness	☐ Hay fever	☐ Colitis	☐ Venereal diseases
☐ Shortness of breath	☐ Indigestion	☐ Hepatitis or jaundice	☐ Anxiety
☐ Abdominal discomfort	☐ Nausea	☐ Thyroid disease	☐ Depression
☐ Swollen ankles	☐ Vomiting	☐ Head or neck radiation	☐ Anemia
☐ Palpitations	☐ Constipation	☐ Headache	☐ Alcohol abuse
☐ Lightheadedness	☐ Diarrhea	☐ Kidney disease	☐ Drug abuse
☐ Frequent urination	☐ Blood in stool	☐ Kidney stones	☐ Gout
☐ Rheumatic fever	☐ Ulcers	☐ Difficulty urinating	☐ Impotence
☐ Asthma	☐ Other		

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This information is for use by your physician as part of your confidential medical record.

Please continue on next page

Gynecologic and Obstetric History

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) _____

Please List and Supply the Dates of:

Operations _____ _____ _____
_____ _____ _____
Hospitalizations other than for surgery _____ _____
_____ _____ _____
Immunization history – have you had: Pheumovax immunization? ☐ No ☐ Yes When? _____
Hepatitis B? ☐ No ☐ Yes When? _____ Flu immunization? ☐ No ☐ Yes When? _____
Other? ☐ No ☐ Yes When? _____ Tetanus immunization? ☐ No ☐ Yes When? _____

When was your last:
Pap smear? _____ Breast Exam? _____ Stool check for blood? _____
Mammogram? _____ Cholesterol check? _____ Prostate exam? _____

Family History Has any member of your family (including parents, grandparents, and siblings) ever had the following?

Illness	Which family members?	Age when diagnosed
Cancer (describe type)		
Hypertension (High blood pressure)		
Heart Disease		
Diabetes		
Strokes		
Mental disease (anxiety, depression, etc.)		
Drug or alcohol addiction		
Glaucoma		
Bleeding diseases		
Other _____		

Medications (Prescription, Over-the Counter, Vitamins, Herbs, etc.)

Drug Name	Dose	Drug Name	Dose	Drug Name	Dose