

# LONE STAR OB/GYN ASSOCIATES

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

## MEDICAL HEALTH HISTORY FORM

**INSTRUCTIONS: Please print or type all information. ALL QUESTIONS MUST BE ANSWERED.**

NAME: \_\_\_\_\_  
Last First Middle

ADDRESS: \_\_\_\_\_  
Street City State Zip Code

HOME PHONE: ( \_\_\_\_\_ ) \_\_\_\_\_ WORK PHONE:( \_\_\_\_\_ ) \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ PLACE OF BIRTH: \_\_\_\_\_

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ BLOOD PRESSURE \_\_\_\_\_

MARITAL STATUS:  Single  Married  Divorced  Separated  Widowed

PRESENT OCCUPATION: \_\_\_\_\_

HIGHEST GRADE OR LEVEL OF EDUCATION: \_\_\_\_\_

List ALL drugs or medications you use regularly (include birth control pills and non-prescription items - laxatives, pain pills, cold tablets, etc.): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When was your last immunization? (tetnus-lock jaw, diptheria, etc.): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### PAST MEDICAL HISTORY:

Do you have an allergic reaction to any foods or drugs?  YES  NO

If "Yes" LIST: \_\_\_\_\_  
\_\_\_\_\_

How many times have you been admitted to a hospital? \_\_\_\_\_

List hospitalizations, starting with most recent:

YEAR	OPERATIONS OR ILLNESSES	HOSPITAL NAME AND LOCATION

HAVE YOU EVER HAD ANY OF THE FOLLOWING PROBLEMS?

YES	NO		EXPLANATORY COMMENTS
<input type="checkbox"/>	<input type="checkbox"/>	AIDS - Acquired Immune Deficiency Syndrome	_____
<input type="checkbox"/>	<input type="checkbox"/>	Anemia (low, weak blood)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis / Rheumatism / Gout	_____
<input type="checkbox"/>	<input type="checkbox"/>	Asthma / Hay Fever	_____
<input type="checkbox"/>	<input type="checkbox"/>	Bowel Disorders / Colitis	_____
<input type="checkbox"/>	<input type="checkbox"/>	Cancer / Tumors	_____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes (sugar)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy (fits, seizures)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema / Bronchitis	_____
<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder trouble or Gallstones	_____
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	_____
<input type="checkbox"/>	<input type="checkbox"/>	Heart trouble or heart murmur	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids (piles)	_____
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	_____
<input type="checkbox"/>	<input type="checkbox"/>	Kidney or Bladder trouble	_____
<input type="checkbox"/>	<input type="checkbox"/>	Nervous / Emotional problems	_____
<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis / Pleurisy	_____
<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia / Pleurisy	_____
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	_____
<input type="checkbox"/>	<input type="checkbox"/>	Stomach trouble / Ulcers	_____
<input type="checkbox"/>	<input type="checkbox"/>	Stroke or paralysis	_____
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease / Goiter	_____
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	_____
<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease (Syphilis)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice / Hepatitis / Liver Cirrhosis	_____

List any other serious illness or injuries you have had (give dates):

\_\_\_\_\_

REVIEW OF SYSTEMS - Have you recently had . . .

YES	NO		EXPLANATORY COMMENTS
<input type="checkbox"/>	<input type="checkbox"/>	Unexpected weight change of more than 10 lbs. in the past year?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Any serious problems with eyes or ears?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Any persistent swollen glands or unusual lumps?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Any breast lumps or nipple discharge?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Your heart frequently racing or skipping beats?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Pain or lightness in your chest with exertion?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Frequent swelling of ankles/legs?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Unusual or severe shortness of breath?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Frequent cough or wheezing?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Any serious difficulty swallowing?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Frequent or severe stomach or abdominal pains?	_____

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

YES	NO	EXPLANATORY COMMENTS
<input type="checkbox"/>	<input type="checkbox"/>	Frequent nausea or vomiting? _____
<input type="checkbox"/>	<input type="checkbox"/>	Frequent or severe constipation or diarrhea? _____
<input type="checkbox"/>	<input type="checkbox"/>	Blood or mucus in a bowel movement? _____
<input type="checkbox"/>	<input type="checkbox"/>	A bowel movement that looked black? _____
<input type="checkbox"/>	<input type="checkbox"/>	Any pain or burning with urination? _____
<input type="checkbox"/>	<input type="checkbox"/>	Unusual frequency or amount of urination? _____
<input type="checkbox"/>	<input type="checkbox"/>	Loss of control of your urine? _____
<input type="checkbox"/>	<input type="checkbox"/>	Any unusual skin problems or persistent sores? _____
<input type="checkbox"/>	<input type="checkbox"/>	Any redness, severe pain, or swelling in your joints? _____
<input type="checkbox"/>	<input type="checkbox"/>	Frequent or severe back pain? _____
<input type="checkbox"/>	<input type="checkbox"/>	Unusually frequent or severe headaches? _____
<input type="checkbox"/>	<input type="checkbox"/>	Serious sexual difficulties? _____
<input type="checkbox"/>	<input type="checkbox"/>	Serious stress from problems at home or work? _____

How many cigarettes do you smoke each day? \_\_\_\_\_ Pipes? \_\_\_\_\_ Cigars? \_\_\_\_\_

Did you ever smoke more than you do now? Yes  No

How much whiskey (liquor) do you drink each day? \_\_\_\_\_ Beer? \_\_\_\_\_ Wine? \_\_\_\_\_

Did you ever drink more than you do now? Yes  No

Have you ever used narcotics or other addictive drugs? Yes  No

Do you wear an auto seat belt? Yes  No  Sometimes

Weight at age twenty? \_\_\_\_\_ pounds

Do you exercise three times a week or more? \_\_\_\_\_ Once a week? \_\_\_\_\_ Less? \_\_\_\_\_

Have you ever been regularly exposed to any chemicals, toxins, poisons, fumes, smoke or radioactive materials at home or at work? Yes  No

Would your religious belief preclude you from receiving certain medical care? Yes  No

Date began last menstrual period \_\_\_\_/\_\_\_\_/\_\_\_\_

Age at onset of menstrual period \_\_\_\_\_ years.

Date of last Pap smear \_\_\_\_/\_\_\_\_/\_\_\_\_

Number of Live births \_\_\_\_\_ Miscarriages \_\_\_\_\_

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Are you now pregnant?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have any unusual problems with your menstrual periods?
<input type="checkbox"/>	<input type="checkbox"/>	Do you examine your breasts each month?
<input type="checkbox"/>	<input type="checkbox"/>	Any complications during pregnancies?
<input type="checkbox"/>	<input type="checkbox"/>	Any unusual vaginal odor, discharge or itching?

**FAMILY HISTORY**

Has any member of your family had any of the following conditions?

CONDITIONS	RELATIONSHIP			
	Mother	Father	Brother/Sister	Brother/Sister
Diabetes	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
If "Yes, state present condition _____				
Cancer	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
If "Yes, state present condition _____				
Heart Problems	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
If "Yes, state present condition _____				
High Blood Pressure	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
If "Yes, state present condition _____				
Stroke	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
If "Yes, state present condition _____				
Living	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

- Have you ever had a T.B. (tuberculosis) skin test? .....  YES  NO
- Have you ever received a blood transfusion? .....  YES  NO
- Have you ever been refused insurance or employment because of your health problems? .....  YES  NO

**HAVE YOU COMPLETED ALL SECTIONS AND ANSWERED ALL QUESTIONS?**