

Medical History _____

Date ___/___/___
Name _____ Age _____ D.O.B. ___/___/___ Sex: M/F
Address _____ Home Phone _____
Occupation _____ Work Phone _____
Emergency Contact _____ Phone _____
Single ___ Married ___ Divorced ___ Widowed ___ Separated ___
Do You Have Children? Yes/No
How did you hear about Commonwealth Medical
Group? _____

Do You Have Allergies to Medications, X-Ray dyes, or other Substances? Yes/No
(If Yes, please list name of medication and type of reaction) _____

Have you had a positive PPD/TB (Tuberculosis test) in the past? Yes/No

Past Medical History (check all that apply)

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Head/Neck problems | <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Skin Disease |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Asthma/Emphysema | <input type="checkbox"/> Anemia | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> GERD/Ulcer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Back Pain |
| <input type="checkbox"/> Kidney Disease/Stones | <input type="checkbox"/> Depression | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Gall Bladder Disease |
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Sexual Dysfunction | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Stomach Disorder | <input type="checkbox"/> Irritable Bowel Syndrome | | |

Review of Symptoms (within the past month)

- | | | |
|---|---|---|
| <input type="checkbox"/> Unexplained Weight loss/gain | <input type="checkbox"/> Changes in Bowel Habits | <input type="checkbox"/> Ear Pain |
| <input type="checkbox"/> Sweats | <input type="checkbox"/> Black Stool | <input type="checkbox"/> Vision Changes |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Chest Pain (tightness) | <input type="checkbox"/> Hair/Nail Changes |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Urinary Problems |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Light Headedness/Dizziness | <input type="checkbox"/> Sexual Function |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Swollen Ankles | <input type="checkbox"/> Blood in Urine |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Frequent Urination |
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> Anxiety/Depression |
| <input type="checkbox"/> Blood in Stool | <input type="checkbox"/> Numbness in Hands/Feet | <input type="checkbox"/> Sinus Pain |

Gynecologic and Obstetric History

Age at onset of menstruation? ___ Frequency: ___ Length of Period: ___
Number of Pregnancies: ___ Births: ___ Abortions: ___
Prolonged Abnormal Bleeding: Yes/No (please describe): ___
History of Abnormal Pap Smear: Yes/No (please describe): ___
Method of Birth Control: _____

Please List and Supply Dates of:

Surgeries: _____

Hospitalizations other than surgery: _____

Immunization History:

Pneumovax Immunization Yes/No Date _____

Hepatitis B Yes/No Date _____

Flu Vaccine Yes/No Date _____

Tetanus Immunization Yes/No Date _____

Other: _____

When was your last:

Pap Smear: _____ Breast Exam: _____ Stool checked for Blood: _____

Mammogram: _____ Cholesterol check: _____ Prostate Exam: _____

Sigmoidoscopy: _____

Family History

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

Illness:	Which family members	Approx. age when diagnosed
Cancer (describe type)	_____	_____
Hypertension (high blood pressure)	_____	_____
Heart Disease	_____	_____
High Cholesterol	_____	_____
Diabetes	_____	_____
Stroke	_____	_____
Mental Disease (anxiety, depression)	_____	_____
Drug or Alcohol addiction	_____	_____
Glaucoma	_____	_____
Bleeding	_____	_____
Thyroid Disease	_____	_____
Rheumatoid Arthritis	_____	_____
Lupus	_____	_____
Other	_____	_____

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

Drug Name	Dose	Drug Name	Dose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Prevention

Do you wear seatbelts? Yes/No

Do you wear a bike helmet? Yes/No

Do you smoke? Yes/No

If yes, How many packs per day? _____

Do you drink alcoholic beverages? Yes/No

If yes, how much per week? _____

Do you drink coffee/tea? Yes/No

If yes, how many cups per day? _____

Do you use drugs? (marijuana ,cocaine, etc) Yes/No

Have you put yourself at risk for AIDS? Yes/No

Have you worked with chemicals? Yes/No

Do you wish to be tested for AIDS? Yes/No

Are you or have you been in a relationship in which you were physically hurt by your partner? Yes/No

Do you obsess about food and/or your weight? Yes/No