



**(PAST MEDICAL HISTORY CONTINUED)**

(date)	<b>Ear Nose &amp; Throat</b>
	Allergic rhinitis
	Chronic Sinus infections
	Recurring Ear infections
	Chronic Tonsil infections
	Ringing in the ears
	Hearing loss
	Vertigo
(date)	<b>Infections</b>
	Hepatitis
	HIV
	Genital Herpes
	Syphilis
	Gonorrhea or Chlamydia
	Tuberculosis (TB)
	Chicken pox or Shingles

(date)	<b>Neurologic Conditions</b>
	Dementia
	Sciatica
	Bell's Palsy
	Seizure disorder
	Carpal tunnel syndrome
	Stroke
	TIA
	Migraine headaches
	Tremor
(date)	<b>Lung Conditions</b>
	Asthma
	COPD
	Pneumonia
	Sleep apnea
	Tobacco use

(date)	<b>Arthritic Conditions</b>
	Rheumatoid arthritis
	Osteoarthritis
	Fibromyalgia
	Chronic low back pain
	Systemic lupus
	Scleroderma
	Sjogren's
	Gout
(date)	<b>Other</b>

**4. PAST SURGICAL HISTORY: (Any surgical procedures with the date they were performed.)**

(date)	Location	Procedure	(date)	Location	Procedure

**FOR YOUNG CHILDREN ONLY:**

Birth weight \_\_\_\_\_ Birth length \_\_\_\_\_ Birth head circumference \_\_\_\_\_ Length of pregnancy \_\_\_\_\_ weeks  
 C-section? Y N APGAR scores (if known): 1 minute \_\_\_\_\_ 5 minutes \_\_\_\_\_ Pregnancy complications? Y N \_\_\_\_\_  
 Primary feeding method: \_\_\_\_\_ Breast – for how long? \_\_\_\_\_ months / years Birth defects? Y N \_\_\_\_\_  
 \_\_\_\_\_ Bottle – what kind of formula? \_\_\_\_\_  
 \_\_\_\_\_ Solids – what types? \_\_\_\_\_

**FOR WOMEN ONLY:**

When was your last pap smear? \_\_\_\_\_ Was it normal? Y N  
 Have you ever had an abnormal pap smear? Y N When? \_\_\_\_\_  
 When was your last menstrual period? \_\_\_\_\_ Are they regular? Y N Cycle length \_\_\_\_\_ days Length of flow \_\_\_\_\_ days  
 When was your most recent mammogram? \_\_\_\_\_ Where was it done? \_\_\_\_\_  
 Have you ever had an abnormal mammogram? Y N When & where? \_\_\_\_\_  
 Have you ever been pregnant? Y N Total number of pregnancies (including miscarriages): \_\_\_\_\_ Number of live births: \_\_\_\_\_  
 Term deliveries: \_\_\_\_\_ Premature births: \_\_\_\_\_ Miscarriages/abortions: \_\_\_\_\_ Number of living children: \_\_\_\_\_

**HEALTH SCREENING TESTS:**

Have you ever had a Colonoscopy or Flexible Sigmoidoscopy? Y N (Routine Colon cancer screening starts at age 50)  
 Why? \_\_\_\_\_ When? \_\_\_\_\_ Result: \_\_\_\_\_  
 Have you ever had a Chest X-Ray? Y N When? \_\_\_\_\_ Result: \_\_\_\_\_  
 Have you ever had a TB skin test (PPD)? Y N When? \_\_\_\_\_ Result: \_\_\_\_\_  
 Have you ever had a Bone Density test? Y N When? \_\_\_\_\_ Result: \_\_\_\_\_

**IMMUNIZATIONS: (for children, please attach a copy of immunization history)**

Adult immunizations:  
 Last Tetanus (needed at least every 10 years): \_\_\_\_\_  
 Pneumovax (needed after age 65 or sooner with certain medical conditions): 1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_  
 Last Flu shot (annual): \_\_\_\_\_ Measles: \_\_\_\_\_ Rubella: \_\_\_\_\_  
 Hepatitis A: 1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_  
 Hepatitis B: 1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_ 3<sup>rd</sup> \_\_\_\_\_

