MEDICAL HEALTH HISTORY FORM

Patient Name: _____ DOB: _____/_____/_____

Signature: _____ Date: _____/_____/_____

Present Health Concerns: _____

MEDICATIONS: *Please list all prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbsetc.*

Medication Name	Dose	Frequency

ALLERGIES: *List all reactions to medicines, foods and other agents.*

Allergy	Reaction or Side Affect

***** If you are on 3 or more medications – please bring them with you to each appointment. *****

PERSONAL MEDICAL HISTORY: *Please indicate whether you have had any of the following medical problems.*

- ☐ Congenital Heart Disease: *please specify*:_____
- ☐ Myocardial Infarction (Heart Attack)
- ☐ Hypertension (High Blood Pressure)
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ Cancer (Malignancy) *please specify*:_____
- ☐ Stroke
- ☐ Coagulation (Bleeding/Clotting)
- ☐ Depression/Suicide Attempt
- ☐ Alcoholism
- ☐ Hepatitis A, B, or C (*specifiy)*_____

Date of Last Colonoscopy: _____
Date of last Tetanus Shot: _____
Date of last HIV Test: _____
Date of Blood Transfusion: _____
Other:_____

SURGICAL HISTORY: *Please list all prior surgeries and dates.*

Surgery	Date

IMMUNIZATIONS: *Please list your most recent immunizations, not including those administered at Lowell General Hospital. Please include your best estimate of the month and year of each immunization.*

Hepatitis A: _____ Measles: _____ Mumps: _____ Rubella: _____ MMR: _____
Hepatitis B: _____ Pneumovax: _____ Tdap: _____ Varicella: _____ Other: _____

WOMEN'S HEALTHY GYNECOLOGIC/OBSTETRIC HISTORY: *(For Women Only)*

# of Pregnancies: _____ # of Deliveries: _____ # of Abortions: _____ # of Miscarriages: ____ Age at 1 st menses: ___
Frequency of menses: _____ Length of menses: _____ Date of last menses: _____ Date of last mammogram: _____

Do you have any concerns about your period or menopause? □ Yes □ No Please explain: _____
Have you ever had an abnormal pap smear? □ Yes □ No If circled yes, when was it? _____