



General History Form

DOB: _____ Age: _____ NAME: _____
 TODAY'S DATE: _____

Do you have any drug allergies? *Yes* *No (If yes, list)* _____
 What is the reason for this visit? _____

PAST HEALTH

PRESENT HEALTH

Have you ever had:

YES NO

Do you feel you have problems with:

YES NO

<u>Heart Disease</u>						<u>Menstrual Periods</u>
<u>Pneumonia</u>						<u>Female Organs</u>
<u>Diabetes/Gestational DM</u>						<u>Breasts</u>
<u>Stomach Ulcers</u>						<u>Weight</u>
<u>Diverticulitis, Colitis</u>						<u>Ears, Eyes, Nose, Throat</u>
<u>Jaundice</u>						<u>Heart</u>
<u>Anemia</u>						<u>Bladder and Kidneys</u>
<u>A Blood Transfusion</u>						<u>Digestion</u>
<u>Varicose Veins</u>						<u>Bowels</u>
<u>Cancer</u>						<u>Rectum</u>
<u>Embolism or Blood Clots</u>						<u>Breathing</u>
<u>Asthma</u>						<u>Joints or Muscles</u>
<u>Mental Problems/Depression</u>						<u>Nerves</u>
<u>Epilepsy</u>						<u>Back</u>
<u>German Measles</u>						<u>Sleeping</u>
<u>Migraine Headaches</u>						<u>Hands or Feet</u>
<u>Kidney or Bladder Disease</u>						<u>Hair</u>
<u>Pelvic Diseases or PID</u>						<u>Depression/Anxiety</u>
<u>Herpes</u>						<u>Sex Life</u>
<u>Gonorrhea</u>						<u>Marriage</u>
<u>Chlamydia</u>						<u>Other Problems</u>
<u>Genital Warts</u>						<u>Syphilis</u>
<u>High Blood Pressure</u>						<u>Other Serious Illness</u>
<u>Did your Mother take DES?</u>						

What medications have you taken in the past month? _____

Do you regularly use any other over the counter medications? *(If yes, list)* _____

Do you use any recreational drugs? *(If yes, list)* _____

Have you ever had a problem with drug use? _____

MENSTRUAL HISTORY

Date of last menstrual period? _____ Latest method of Birth Control? _____

Previous methods of Birth Control? _____

Do you consider your period normal? *Yes No* How often do you flow? _____



OPERATIONS

YEAR OPERATION CITY SURGEON COMPLICATIONS
