

**UROGYNECOLOGY ASSOCIATES OF PHILADELPHIA
PAST MEDICAL HISTORY FORM**

NAME: _____

BIRTH DATE: ___/___/___

DATE: ___/___/___

ADDRESS: _____

CITY _____

STATE/ZIP: _____

REVIEW OF SYSTEMS

PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLY TO YOU NOW, IN THE PAST OR OFTEN

	CURRENTLY	PAST	NOTES
1. CONSTITUTIONAL			
Weight loss	<input type="checkbox"/>	<input type="checkbox"/>	
Weight gain	<input type="checkbox"/>	<input type="checkbox"/>	
Fever	<input type="checkbox"/>	<input type="checkbox"/>	
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	
2. EYES			
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	
Spots before eyes	<input type="checkbox"/>	<input type="checkbox"/>	
Vision changes	<input type="checkbox"/>	<input type="checkbox"/>	
3. ENT/MOUTH			
Ear aches	<input type="checkbox"/>	<input type="checkbox"/>	
Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>	
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	
Mouth sores	<input type="checkbox"/>	<input type="checkbox"/>	
Dental problems	<input type="checkbox"/>	<input type="checkbox"/>	
4. CARDIOVASCULAR			
Painful breathing	<input type="checkbox"/>	<input type="checkbox"/>	
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	
Difficult breathing on exertion	<input type="checkbox"/>	<input type="checkbox"/>	
Swelling of legs	<input type="checkbox"/>	<input type="checkbox"/>	
Palpitations of heart	<input type="checkbox"/>	<input type="checkbox"/>	
5. RESPIRATORY			
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	
Spitting up blood	<input type="checkbox"/>	<input type="checkbox"/>	
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	
Cough, chronic	<input type="checkbox"/>	<input type="checkbox"/>	
6. GASTROINTESTINAL			
Diarrhea, frequent	<input type="checkbox"/>	<input type="checkbox"/>	
Bloody stool	<input type="checkbox"/>	<input type="checkbox"/>	
Nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>	
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	
7. GENITOURINARY			
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	
Pain with urination	<input type="checkbox"/>	<input type="checkbox"/>	
Urgency	<input type="checkbox"/>	<input type="checkbox"/>	
Frequency of urination	<input type="checkbox"/>	<input type="checkbox"/>	
Incomplete emptying	<input type="checkbox"/>	<input type="checkbox"/>	
Stress incontinence	<input type="checkbox"/>	<input type="checkbox"/>	
Abnormal periods	<input type="checkbox"/>	<input type="checkbox"/>	
Painful intercourse	<input type="checkbox"/>	<input type="checkbox"/>	
8. MUSCULOSKELETAL			
Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>	
9. SKIN/BREAST			
Pain in breast	<input type="checkbox"/>	<input type="checkbox"/>	
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	

PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLY TO YOU NOW, IN THE PAST OR OFTEN			
Masses	<input type="checkbox"/>	<input type="checkbox"/>	
Rash	<input type="checkbox"/>	<input type="checkbox"/>	
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	
10. NEUROLOGICAL			
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	
Numbness	<input type="checkbox"/>	<input type="checkbox"/>	
Trouble walking	<input type="checkbox"/>	<input type="checkbox"/>	
11. PSYCHIATRIC			
Depression	<input type="checkbox"/>	<input type="checkbox"/>	
Crying, frequent	<input type="checkbox"/>	<input type="checkbox"/>	
12. ENDOCRINE			
Dry skin	<input type="checkbox"/>	<input type="checkbox"/>	
Abnormal thirst	<input type="checkbox"/>	<input type="checkbox"/>	
Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>	
13. HEMATOLOGIC/LYMPHATIC			
Bruises, frequent	<input type="checkbox"/>	<input type="checkbox"/>	
Cuts do not stop bleeding	<input type="checkbox"/>	<input type="checkbox"/>	
Enlarged lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>	
14. ALLERGIC/IMMUNOLOGIC			
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	
Drugs, other	<input type="checkbox"/>	<input type="checkbox"/>	

PERSONAL PAST HISTORY

MAJOR ILLNESSES	Yes	No		Y E S	NO
Asthma			Cancer		
Pneumonia			Ulcers		
Chronic Lung Disease			Depression/anxiety		
Kidney Infections/stones			Anemia/Blood transfusions		
Tuberculosis			Seizures/convulsions/epilepsy		
Venereal Disease			Bowel trouble		
Heart Trouble/murmur			Glaucoma		
Diabetes			Arthritis/joint pain		
High Blood Pressure			Fracture		
Stroke			Hepatitis/Yellow jaundice		
Rheumatic Fever			Thyroid Disease		
OPERATIONS/HOSPITALIZATIONS					
Reason		Date	Reason		Date
INJURIES/ILLNESSES					
Type		Date	Type		Date
LAST IMMUNIZATION OR TEST					
		Date			Date
Tetanus			Pneumonia		
Flu Shot			TB Skin Test		
OB/GYN HISTORY					
		Number			Number
Births			Abortions		
Miscarriages			Living children		
CURRENT MEDICATIONS					
Drug Name		Dosage	Drug Name		Dosage

FAMILY HISTORY

Illness	Yes	Relative	Illness	Yes	Relative
Diabetes			Drinking Problem		
Stroke			Breast Cancer		
Heart Disease			Colon Cancer		
High Blood Pressure			Ovarian Cancer		

SOCIAL HISTORY

Habits						
Smoking	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Packs per day_____	Years_____
Alcohol	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Drinks per day_____	Drinks per week_____
Drug Use	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>		
Seat Belt Use	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>		
Regular Exercise	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>		
Personal Profile						
Marital Status	Married	<input type="checkbox"/>	Single	<input type="checkbox"/>	Widowed	<input type="checkbox"/>
					Divorced	<input type="checkbox"/>
Number of Living Children	_____					
Number of people in household	_____					
School Completed	High School	<input type="checkbox"/>	College	<input type="checkbox"/>	Graduate Degree	<input type="checkbox"/>
					Other	<input type="checkbox"/>
Current or most recent job	_____					

Completed by: Patient Office Nurse Physician

Signature of patient: _____

Date reviewed by physician with patient: _____

Physician Signature: _____

Annual Review of History

Date reviewed: _____ Physician Signature: _____

Date reviewed: _____ Physician Signature: _____

Date reviewed: _____ Physician Signature: _____

Date reviewed: _____ Physician Signature: _____