Lawrence Medical Associates, P.C.

MEDICAL HISTORY

Name _____ DOB: _____ Date: _____

Problems *(State reasons you want to see a doctor. List in order of importance to you)*

- _____
- _____

Allergies to Medications, foods, tape, Latex, Other: List and describe the reaction

_____

_____

Medications: *(prescribed, over the counter, vitamins, herbs)*

_____ _____

_____ _____

_____ _____

Past Medical History and Review of Symptoms:

Please circle if you have had problems with or are presently experiencing any of the following:

High Blood Pressure	Indigestion	Hemorrhoids	Cancer
Diabetes	Nausea/Vomiting	Hernia	Arthritis/ Gout
High Cholesterol	Change in Bowel habits	Breast Lump	Headache
Weight Loss/gain	Diarrhea	Thyroid Disease	Depression
Heart Problems	Constipation	Bleeding Problem	Anxiety
Chest pain/tightness	Jaundice/Hepatitis	Anemia	Alcohol/Drug Abuse
Persistent cough	Barrette Esophagus	Lightheadedness	Psychiatric problems
Bronchitis/Pneumonia	Peptic Ulcer Disease	Blood Clot: legs/Lung	Epilepsy
Asthma	Gall Bladder Disease	Kidney Stones	Sexually Transmitted Disease
Tuberculosis	Blood in stool	Frequent urination	Herpes
Abdominal pain	Colonic Polyps	Skin Disease	AIDS/ HIV

*Other:*_____

GYNECOLOGIC AND REPRODUCTIVE HISTORY *(Female Patients)*

Are you pregnant? □Y □ N Are you Menopause? □Y □N Date of last menstrual period _____

Age at onset of Menstrual Cycle: _____ Frequency: _____ Length of menstruation: ___ Days

Pregnancies: ____ Age at first pregnancy ____ Births: _____ Miscarriages/Abortion : __

Prolonged/abnormal Bleeding: □Y □N Pelvic Pain: □Y □N Abnormal Discharge: □Y □N

History of Abnormal Pap Smear: □Y □ N History of Breast Feeding? □Y □N

Have you ever used: □Birth Control Pills □ Patch □Other contraceptive Devices

Specify Medication/Duration of Use/ Date of last use: _____

Hormonal Replacement Treatment? □Y (Specify Medication/Duration of use/ Date of last use) □ N

_____

History of Infertility Treatment ? □ Y □ N

Please List and provide the dates on:

Operations: _____

Hospitalizations: _____

Did you or a family member ever had problem during Anesthesia? □ Y (Explain Below) □ N

_____

Do you agree with transfusion of blood and blood products if medically indicated? □ Y □ N

When was your last?

PAP Smear _____ Mammogram _____ Breast Exam _____

Prostate Exam _____ Stool Check for Blood _____ Colonoscopy _____

Social History and Life Style

Marital Status: □Single □Married □Widowed □ Divorced □Common Law Partner

Whom do you live with? _____ Religious Preference? _____

Do you drink Coffee? □ Yes □ No Do you smoke cigarettes? □ Yes □ No

Do you drink Alcoholic beverages? □ Y □ No Do you use drugs? □Yes □ No

Have you ever worked or have been exposed to □ Chemicals □ Radionuclides □ Radiation

Method of birth Control: _____

Family History: *(has any member of your family, including parents, grandparents, siblings, and children ever had the following)*

Illness	**Who**
Cancer	_____
High blood pressure	_____
Heart Disease	_____
Stroke	_____
Mental Disease	_____
Drug/Alcohol use	_____
Glaucoma	_____
Bleeding Disease	_____

Other _____

Patient's Signature _____