MEDICAL HISTORY

Name: _____ DOB: _____

Menstrual Age Onset: _____ Regularity: _____

Last Period: _____ Last Pap Test: _____

Birth Control Method: _____ Sexual Activity Status: Active Non

Surgeries: _____

Allergies: _____

Current Prescription Medications: _____

Significant Past Illnesses: _____

Do you smoke?: (Circle One) Y / N Amount: _____

Do you drink alcoholic beverages? Y / N Frequency: _____

Do you use recreational drugs? Y / N Which ones: _____

Daily caffeine intake: (coffee, cola, etc.): _____

Family History of Osteoporosis: _____

_____

# of Pregnancies: _____ # of Miscarriages: _____

# of Terminations: _____ # of Premature Births: _____

Delivery Date:	C-Sect / Vaginal	# of Months	Sex	Birth Weight	Problems:

General Past Medical History

Check off any and all of the problems you have had during your lifetime:

- □ Heart Disease
- □ Kidney Disease
- □ Diabetes, Onset _____ Age
- □ Thyroid Disease
- □ Breast Disease
- □ Gallbladder Disease
- □ Headaches
- □ Epilepsy
- □ Lactose Intolerance
- □ Liver Disease / Hepatitis, Type _____
- □ Lung Disease / Asthma, COPD
- □ Rheumatoid / Arthritis
- □ Emotional Concerns
- □ Eating Disorders
- □ Gastrointestinal / Ulcers
- □ Ovaries Removed Before Menopause
- □ Weight Gain
- □ Height Loss
- □ Fractures Bones
- □ Vision
- □ Hearing
- □ Back Problems
- □ Hypertension

Is there anything else that we should know about your health, history, or lifestyle that is important in our caring for you today? _____

_____

Patient: _____ Date: _____