

FEMALE ADULT MEDICAL HISTORY FORM

Name: _____ Age: _____ Sex: _____ Birthdate: _____

Marital Status: _____ If married, name of spouse: _____

Address: _____

City _____ State _____ Zip Code _____

Telephone: Work: _____ Home: _____

Occupation: _____

Name and Address of Employer: _____

Spouse's Employer & Address: _____

Your Social Security Number: _____ Spouse's Number: _____

Type of Medical Insurance: _____ Number of Policy: _____

Name, address and phone number of closest relative other than spouse:

Family physician, address and phone number: _____

Who referred you to our offices? _____

Please complete the following table with particular attention to the presence of diseases.

Relation	Living or Deceased		Present Cause of Death	Other Diseases	Age	Age at Death
Father	L	D				
Mother	L	D				
Maternal G-Mother	L	D				
Maternal G-Father	L	D				
Paternal G-Mother	L	D				
Paternal G-Father	L	D				
Brother	L	D				
Brother	L	D				
Brother	L	D				
Brother	L	D				
Sister	L	D				
Sister	L	D				
Sister	L	D				
Sister	L	D				

MEDICATIONS AND SUPPLEMENTS

- | | |
|----|-----|
| 1. | 6. |
| 2. | 7. |
| 3. | 8. |
| 4. | 9. |
| 5. | 10. |

PAST MEDICAL HISTORY

1. List hospital admissions including surgeries:

<u>Reason</u>	<u>Date</u>
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2. List medical conditions:

3. Allergies to medications:

4. Menstrual History

First menses (age at onset)

Regular or irregular?

Menopause?

Premenopause?

PMS Symptoms

Use of birth control pills?	Past	Present
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5. Infection history

<u>Frequency</u> (Rare, Average or Frequent)	<u>Childhood</u>	<u>Adulthood</u>
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Ear

Sinusitis

Bronchitis/Pneumonia

Vaginal Yeast

Urinary Tract

Other

6. Allergy History Form

Circle the symptoms you have experienced:

NOSE

itching sneezing post nasal drip drainage stuffiness
snoring nosebleeds mouth breathing

EYES

itching excessive tearing dark circles under eyes redness

EARS

itching frequent infections dizziness difficulty hearing tinnitus
popping fullness pressure fluid in ears drainage

THROAT

sore throat hoarseness frequent clearing of throat
increased mucous in the morning postnasal drip itching

CHEST

cough asthma frequent bronchitis
wheezing with colds or exposure to dust, pollen, animals

GASTROINTESTINAL

bloating heartburn excessive gas loose bowel movements
diarrhea constipation retasting food poor appetite rectal itching

GENITOURINARY

frequency urgency burning itching

SKIN

hives rashes eczema excessive perspiration
athlete's foot

MUSCULOSKELETAL

joint pain muscle pain neck pain back pain

NEUROLOGICAL

headache (sinus, migraine, tension, vascular, muscular)
decreased attention span lack of concentration/forgetfulness
hyperactivity seizures moodiness

GENERAL

lack of energy inability to lose weight recent weight loss

Do you have symptoms under the following conditions?

Indoors	Outdoors	Weather Change	Wet Weather		
Hot Days	Cold Days	Summer	Fall	Winter	Spring
Heating System on		Air Conditioning on		Grass	Plants
Basement		Bathroom			

What type of pet(s) do you have?

Symptoms with exposure to: Cats Dogs Others

7. Do any foods cause symptoms? If so, list symptoms:

Foods Symptoms

What foods do you crave or eat frequently?

Do you eat these foods more than twice a week?

Milk Beef Soybean Corn
Wheat Baker's Yeast Brewer's Yeast Eggs Cane Sugar Malt Rice
Coffee Tea Onions Garlic Black Pepper Coconuts Pork Peanut
Chocolate Chicken Fish Oranges Tomatoes Lettuce
Potatoes String Beans Apples

8. List any symptoms when exposed to:

Cosmetics

Hair spray

Cleaning sprays and solution

Insecticides

In stores

Gasoline fumes

Cigarette Smoke

Newsprint

What type of heat does your home have? (gas, electric, etc.)

Is heat delivered by blower, radiator, or electric panels?

Do you use kerosene heaters? No Yes

Do you use a wood stove? No Yes

Do you use a humidifier? No Yes

What type of water do you have? City Well

Do you have an air-conditioner... at work? No Yes

at home No Yes

in your bedroom? No Yes

Central? No Yes

Do you live near any chemical plants, furniture plants, or clothing manufacturers?

No Yes If so, which one(s)?

How close are you to it?

Do you sleep with a pillow? No Yes Is it Dacron? No Yes

Foam rubber No Yes Feather No Yes

Is your mattress cotton? No Yes Feather No Yes

Foam rubber? No Yes Horse hair? No Yes

Is your furniture upholstered? No Yes What type of fabric?

What type of floor covering (carpeting, rugs, linoleum)?

What type of wall covering (wallpaper, fabric, paneling)?

What type of window covering (curtains, drapes, shades, blinds)?

List any past treatment for any of your complaints/symptoms

Any other medical problems or conditions?

Does anyone in the family have similar problems? No Yes

If so, who?

Any family history of hayfever? No Asthma No Yes

Headaches? No Yes Depression No Yes Food allergy No Yes

Hives? No Yes Eczema? No Yes Chronic skin disease? No Yes

Have you previously been evaluated by an allergist? No Yes

If so, what was your experience?

9. Do you smoke? No Yes If yes, do you inhale? No Yes

What form(s) of tobacco? _____

How often? _____

Began smoking at what age? _____

Please estimate your consumption of alcoholic beverages? _____

Per week: _____ Per month: _____

What foods must you avoid? _____

Do you consider your diet adequate? _____

Do you eat differently than most of the people you know?

How many hours of sleep do you require? _____ per 24 hours.

Do you sleep soundly? No Yes

If no, please state reason _____

How much coffee per day do you drink? _____ cups. Tea? _____ cups.

Please list those places you have lived longer than one month:

List those countries other than Canada which you have visited:

List any unusual habits or avocations you may have:

List any impediments to your activity:

10. Summary of primary medical concerns: