Dr Shelley Giebel at Healthy Success

Medical History Update

In an effort to serve you better, we request that you answer the following questions. We need this information to give you the best care and treatment possible. All information is held strictly confidential and is released only with your written consent. If a question doesn't pertain to you, please ignore. Thank you!

LAST NAME: _____ FIRST NAME: _____ TODAYS DATE: _____

MEDICAL HISTORY

FIRST DAY OF YOUR LAST MENSTRUAL PERIOD (BEST APPROXIMATION): _____

HAVE YOU HAD ANY ILLNESSES OR DISEASES SINCE YOUR LAST VISIT? **YES** OR **NO**

IF YOU ANSWERED YES, PLEASE EXPLAIN: _____

_____

HAVE YOU HAD ANY SURGERIES SINCE YOUR LAST VISIT? **YES** OR **NO**

IF YOU ANSWERED YES, PLEASE LIST ANY PROCEDURES PERFORMED:

NAME OF OPERATION	DATE PERFORMED	ANY COMPLICATIONS?
_____	_____	_____
_____	_____	_____

HAVE YOU HAD ANY CHANGES IN YOUR FAMILY HISTORY? **YES** OR **NO**

IF YOU ANSWERED YES, PLEASE EXPLAIN: _____

_____

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? **YES** OR **NO**

IF YOU ANSWERED YES, PLEASE LIST HERE: (Are you taking birth control pills? Please list here)

NAME OF MEDICATION	DOSAGE	REASON FOR TAKING
_____	_____	_____
_____	_____	_____

HAVE YOU DEVELOPED ANY NEW ALLERGIES? **YES** OR **NO**

IF YOU ANSWERED YES, PLEASE EXPLAIN: _____

_____

DO YOU DESIRE A SEXUALLY TRANSMITTED DISEASE (STD) SCREENING OR AIDS TEST? **YES** OR **NO**

IF YOU ANSWERED YES, PLEASE EXPLAIN: _____

_____

IF THERE ARE ANY OTHER SPECIAL CONCERNS YOU WOULD LIKE TO DISCUSS WITH YOUR DOCTOR, PLEASE EXPLAIN BELOW:

_____

_____

Thank you for providing us with this very important information.