Dr Shelley Giebel at Healthy Success

Medical History Form

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: _____ AGE: _____ TODAYS DATE: _____

MEDICAL HISTORY

OF PREGNANCIES: _____ # OF DELIVERIES: _____ # OF LIVING CHILDREN: _____

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

ARE YOUR PERIODS NORMAL?: _____ IF NOT, PLEASE EXPLAIN: _____

_____

HOW OFTEN ARE YOUR PERIODS?: _____ HOW LONG DO YOUR PERIODS LAST?: _____

WHAT AGE DID YOU FIRST START HAVING PERIODS?: _____ HAVE YOU HAD PERMANENT STERILIZATION?: _____

ARE YOU CURRENTLY PREGNANT?: _____ ARE YOU USING BIRTH CONTROL?: _____ IF SO, WHAT TYPE?: _____

HAVE YOU ENTERED MENOPAUSE?: _____ IF SO, HAVE YOU HAD ANY BLEEDING? (PLEASE EXPLAIN): _____

_____

HAVE YOU HAD A PAP SMEAR TEST?: _____ IF SO, WHEN WAS YOUR LAST PAP TEST?: _____

HAVE YOU EVER HAD AN ABNORMAL PAP SMEAR?: _____ IF SO, PLEASE EXPLAIN: _____

_____

HAVE YOU HAD A CHOLESTEROL TEST?: _____ IF SO, WHEN WAS YOUR LAST TEST?: _____

WAS YOUR CHOLESTEROL NORMAL AT THAT TIME?: _____

HAVE YOU HAD A MAMMOGRAM?: _____ IF SO, WHEN WAS YOUR LAST MAMMOGRAM?: _____

WAS YOUR MAMMOGRAM NORMAL AT THAT TIME?: _____

YOUR MEDICAL HISTORY – PLEASE CIRCLE ANY PROBLEM(S) YOU HAVE/HAD

HEART DISEASE	CANCER	DIABETES
URINARY PROBLEMS	STROKES	LUNG DISEASE
HIGH BLOOD PRESSURE	LIVER DISEASE	THYROID DISEASE
OSTEOPOROSIS	PEPTIC ULCER DISEASE	INJURIES
GALL BLADDER DISEASE	HIV	OTHER _____

OPERATIONS – PLEASE LIST ANY PROCEDURES PERFORMED

NAME OF OPERATION	YEAR PERFORMED	COMPLICATIONS
_____	_____	_____
_____	_____	_____

MEDICATIONS – PLEASE LIST DOSAGES AND HOW OFTEN TAKEN (Are you taking birth control pills? Please list here)

_____

_____

ALLERGIES TO MEDICATIONS – PLEASE LIST TYPE AND SYMPTOMS IF TAKEN

_____

_____

DO YOU EXERCISE?: _____ WHAT TYPE(S)?: _____ HOW OFTEN?: _____

HAVE YOU SMOKED?: _____ DO YOU STILL SMOKE?: _____ FOR HOW LONG?: _____ HOW MANY PER DAY?: _____

DO YOU DRINK ALCOHOL?: _____ WHAT TYPE(S)?: _____ HOW OFTEN?: _____

HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE PAST YEAR? (Please Circle)

CORTISONE THYROID PILLS ILLEGAL DRUGS ASPIRIN BIRTH CONTROL PILLS

HAVE YOU HAD A BLOOD TRANSFUSION?: _____ IF SO, WHEN?: _____

FAMILY MEDICAL HISTORY – PLEASE CIRCLE ANY PROBLEM(S) YOUR FAMILY MEMBERS HAVE/HAD

HEART DISEASE	CANCER	DIABETES
URINARY PROBLEMS	STROKES	LUNG DISEASE
HIGH BLOOD PRESSURE	LIVER DISEASE	THYROID DISEASE
OSTEOPOROSIS	PEPTIC ULCER DISEASE	INJURIES
GALL BLADDER DISEASE	OTHER _____	

IF CIRCLED, PLEASE EXPLAIN & LIST MATERNAL/PATERNAL RELATIONSHIP IF POSSIBLE:

_____

SEXUAL HISTORY

ARE YOU CURRENTLY SEXUALLY ACTIVE?: _____ IF SO, HOW MANY PARTNERS THIS YEAR?: _____

IS SEX SATISFACTORY?: _____ IF NOT, PLEASE EXPLAIN?: _____

HISTORY OF SEXUALLY TRANSMITTED DISEASES (STDs)?: _____ IF SO, WHAT TYPE(S)?: _____

DO YOU WANT TO BE TESTED FOR STDs?: _____ DO YOU WANT AN AIDS TEST (Please Explain)?: _____

HAVE YOU EVER BEEN A VICTIM OF PHYSICAL OR SEXUAL ABUSE?: _____

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.