ROWAN UNIVERSITY
School of Osteopathic Medicine

# MEDICAL HISTORY

**Date:** / /

Name______________________ Age________ Birthdate______________________

Address______________________ Sex ☐ M ☐ F Social Security #______________________

______________________ Home Phone____________ Cell Phone______________

Emergency Contact______________________ Emergency Contact Phone______________________

Occupation______________________ Work Phone________ Referred by______________________

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner

If married, spouse's name______________________ Children's Names/Ages______________________

Allergies to medications, X-ray dyes, latex, IV contrast, or other substances? ☐ No ☐ Yes

If yes, please list and describe: ______________________

______________________

## PAST MEDICAL HISTORY AND REVIEW OF SYSTEMS

Please check **all that apply** if you have had problems with or are presently complaining of any of the following:

| | | | |
|---|---|---|---|
| ☐abdominal discomfort | ☐congestive heart failure | ☐heart disease | ☐persistent cough |
| ☐alcohol abuse | ☐constipation | ☐hemorrhoids | ☐pneumonia |
| ☐anemia | ☐depression | ☐hepatitis or jaundice | ☐rheumatic fever |
| ☐anxiety | ☐diabetes | ☐high blood pressure | ☐shortness of breath |
| ☐arthritis | ☐diarrhea | ☐indigestion | ☐skin diseases |
| ☐asthma | ☐difficulty urinating | ☐kidney diseases | ☐swollen ankles |
| ☐blood disorders | ☐drug abuse | ☐kidney stones | ☐T.B. |
| ☐blood in stool | ☐frequent urination | ☐lightheadedness | ☐thyroid disease |
| ☐bronchitis | ☐gallbladder disease | ☐low back problems | ☐ulcers |
| ☐cancer | ☐gout | ☐nausea | ☐unexplained weight gain/loss |
| ☐change in bowel habits | ☐hay fever | ☐osteoporosis | ☐venereal diseases |
| ☐chest pain/chest tightness | ☐head or neck radiation | ☐palpitations | ☐vomiting |
| ☐colitis | ☐headache | | |

Other: ______________________

______________________

**PLEASE LIST AND SUPPLY THE DATES OF:**

**OPERATIONS:** ______________________

______________________

______________________

______________________

**HOSPITALIZATIONS:** ______________________
*(other than surgery)* ______________________

______________________

______________________

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**PATIENT NAME:** ______________________ **Date:** ___/___/___

## IMMUNIZATION HISTORY – HAVE YOU HAD:

| | | | | | |
|---|---|---|---|---|---|
| Pneumovax immunization? | ☐No ☐Yes | When? ______ | Flu immunization? | ☐No ☐Yes | When? ______ |
| Tetanus immunization? | ☐No ☐Yes | When? ______ | Hepatitis B? | ☐No ☐Yes | When? ______ |
| Other: | ☐No ☐Yes | When? ______ | | ☐No ☐Yes | |

## WHEN WAS YOUR LAST:

| | | | | | |
|---|---|---|---|---|---|
| Pap smear? | ______ | Breast exam? | ______ | Stool check for blood? | ______ |
| Mammogram? | ______ | Prostate exam? | ______ | Cholesterol check? | ______ |
| Colonoscopy? | ______ | | ______ | | ______ |

## GYNECOLOGIC AND OBSTETRIC HISTORY

Age at onset of period______ Frequency______ Length of period______

Pregnancies______ Births______ Miscarriages______

| | | | | | |
|---|---|---|---|---|---|
| Prolonged or abnormal bleeding | ☐ No | ☐ Yes | Abnormal discharge | ☐ No | ☐ Yes |
| Leakage of urine | ☐ No | ☐ Yes | History of abnormal Pap smear | ☐ No | ☐ Yes |
| Pelvic pain | ☐ No | ☐ Yes | | | |

If yes, please describe: ______________________

## FAMILY HISTORY: Has any member of your family (including parents, grandparents, and siblings) ever had the following?

| ILLNESS | WHICH FAMILY MEMBERS | AGE WHEN DIAGNOSED |
|---|---|---|
| Cancer *(describe type)* | | |
| Diabetes | | |
| Heart Disease | | |
| Hypertension *(high blood pressure)* | | |
| Mental Disease *(anxiety, depression, etc.)* | | |
| Stroke(s) | | |
| Other *(describe)* | | |

## PREVENTION

| | | | |
|---|---|---|---|
| Do you wear seatbelts? | ☐ No | ☐ Yes | If no, why not? ______ |
| Do you wear a bike helmet? | ☐ No | ☐ Yes | ☐ Not applicable ______ |
| Do you smoke? | ☐ No | ☐ Yes | If yes, how many packs per day? ______ |
| Do you drink alcoholic beverages? | ☐ No | ☐ Yes | If yes, how much per week? ______ |
| Do you drink coffee? | ☐ No | ☐ Yes | If yes, how many cups per day? ______ |
| Do you drink tea? | ☐ No | ☐ Yes | If yes, how many cups per day? ______ |
| If there is a gun in your home, is it out of children's reach and unloaded? | ☐ No | ☐ Yes | ☐ Not applicable |
| Do you use drugs (marijuana, cocaine, crack, etc.) | ☐ No | ☐ Yes | If yes, explain: ______ |
| Have you ever engaged in any activity which has put you at risk of getting AIDS? | ☐ No | ☐ Yes | If yes, explain: ______ |
| Do you wish to be tested for AIDS? | ☐ No | ☐ Yes | |
| Have you ever worked with chemicals, paints, asbestos, or other hazardous materials? | ☐ No | ☐ Yes | If yes, explain: ______ |
| Are you in a relationship in which you have been physically hurt (i.e., slapped, kicked, punched, bruised) by your partner? | ☐ No | ☐ Yes | |
| Do you ever feel afraid of your partner? | ☐ No | ☐ Yes | |
| Do you have a "living will?" | ☐ No | ☐ Yes | |
| Do you have a donor card? | ☐ No | ☐ Yes | |
| Method of birth control? | ☐ No | ☐ Yes | If yes, explain: ______ |

| | |
|---|---|
| **I hereby authorize RowanSOM to release any medical information that may be necessary for either medical care or insurance purposes.** | **Signature:** |