

Patient's Personal History

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Date: _____

Please complete these forms. If you do not understand any of the questions, please ask the doctor.
This is a confidential record. Information contained here will not be released except when you have authorized us to do so.

Name _____
Last Name First Name Middle Name

Race _____ Religion _____

Family History

	If Living			If Deceased	
	Sex	Age	Present Health	Age at Death	Cause
Father					
Mother					
Brothers/Sisters					
Husband					
Sons/Daughters					

Do you or any member of your family have or ever had? (Please circle & give relationship)

Asthma _____
 Diabetes _____
 Hepatitis _____
 Bleeding Tendency _____
 Cystic Fibrosis _____
 Mental Retardation _____
 Downs Syndrome _____
 Hydrocephalus/Spina Bifida _____
 Tay Sachs _____
 Colitis/Ulcers _____

Epilepsy _____
 Heart Disease _____
 High Cholesterol Level _____
 Heart Defects _____
 High Blood Pressure _____
 Stroke _____
 Herpes _____
 Goiter/Thyroid Problem _____
 Congenital Defects _____
 Sexually Transmitted Disease _____

CANCERS (family or self):

Breast _____
 Cervix _____
 Uterus _____

Ovaries _____
 Colon _____
 Other _____

Name: _____

Personal Medical History

MEDICATIONS:

Are you presently taking any of the following medications? (Please circle)

Yes	No	Aspirin, bufferin, anacin	Yes	No	Tranquilizers
Yes	No	Blood pressure pills	Yes	No	Weight reducing pills
Yes	No	Cortisone	Yes	No	Blood thinning pills
Yes	No	Cough medicine	Yes	No	Dilantin
Yes	No	Digitalis (Heart pills)	Yes	No	Shots
Yes	No	Hormones	Yes	No	Water Pills
Yes	No	Insulin or diabetic pills	Yes	No	Antibiotics
Yes	No	Iron or "poor blood" medications	Yes	No	Barbituates
Yes	No	Laxatives	Yes	No	Birth control pills, brand name: _____
Yes	No	Sleeping Pills	Yes	No	Phenobarbital
Yes	No	Thyroid Pills	Yes	No	Other drugs not listed - If so, please list.

OPERATIONS:

List the operations (major or minor) you have had as well as the hospital location and date:

ILLNESSES OR DISEASES:

List the names of any diseases or illnesses you have now or had in the past:

ALLERGIES:

List the names of any drugs to which you are allergic and state the reaction you have had:

INJURIES OR ACCIDENTS :

List any serious injuries or accidents you have had and the date:

Name: _____

**Personal Medical History
Continued**

MENSTRUAL HISTORY:

Age of onset of menses _____ Duration of menses _____ Interval between menses _____

First day of last menstrual period _____

Please circle

- Yes No Have you ever missed a period except when pregnant?
Yes No Has your period ever lasted more than eight days or less than two days?
Yes No Did you ever pass large clots during your period?

CONTRACEPTIVE HISTORY:

Please circle

- Yes No Have you ever taken birth control pills?
Yes No Are you presently taking birth control pills? Which one? _____
If no, what form of contraception do you use? _____

OTHER:

Please circle

- Yes No Do you have urinary problems? Please explain:

Yes No Do you have varicose veins?
Yes No Do you have phlebitis or inflamed leg veins?

PERSONAL HABITS & PRACTICES:

Please circle

- Yes No Do you regularly smoke? Cigarettes _____ Packs/day _____ For how many years? _____
Yes No Do you usually drink over 4 cups of coffee per day?
Yes No Do you regularly drink alcohol? 1 oz. per day 2 oz. per day 4 oz. per day over 5 oz.
Yes No Beer: 1 bottle per day 2 bottles per day over 4 bottles per day
Yes No Do you regularly have a Pap smear?
Date and result of last Pap smear _____
 Normal Abnormal
Yes No Do you regularly perform monthly self breast examinations?
Yes No Have you ever had a mammogram?
If yes, date and result of last mammogram _____
Yes No Have you ever had your cholesterol checked?
If yes, date and result _____

Name: _____

**Personal Medical History
Continued**

OBSTETRICAL HISTORY (including miscarriages and elective abortions):

Date (Month/Year)	Full Term, Premature, Or Abortion	Vaginal or C-Section Delivery	Hours In Labor	Sex & Birth Weight	Complication Mother or Baby