



SABRINA HARRISON, M.D., P.C.

MEDICAL HISTORY

Name _____ DOB _____ Date _____

Primary Care Physician _____

Please state the reason for your appointment today? _____

OBSTETRICAL HISTORY

Total number of times pregnant _____ Set of twins _____ Full Term Babies _____

Premature Babies _____ Miscarriages _____ Stillbirths(# of weeks) _____ Abortions _____

GYNECOLOGICAL HISTORY

Date of last menstrual period _____ Frequency of periods _____ Age at menarche _____

of pads/tampons used on heaviest days _____ Clots? _____ Painful menses? _____

If not menstruating, age when stopped? _____ Any bleeding or spotting since stopped? _____

Ever had sex? _____ Currently sexually active? _____ Pain with intercourse? _____

Heterosexual _____ Homosexual _____ Bisexual _____

Are there any questions concerning sex that you would like to discuss with your doctor? _____

Date of last Pap smear? _____ Place? _____ Normal/Abnormal

Have you ever had treatment for the following? Herpes _____ Gonorrhea _____

Chlamydia _____ Warts _____ Syphilis _____ Trichomonas _____

Have you ever had a problem with chronic vaginitis? _____

Type of contraception you are now using _____

Are you satisfied with this method? _____ What have you used in the past? _____

Last Mammogram _____

Do you perform monthly self breast exams? _____



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PERSONAL AND FAMILY MEDICAL HISTORY

ILLNESSS	WHOM/DATE	ILLNESS	WHOM/DATE
DIABETES		THYROID DISEASE	
HYPERTENSION		HEART ATTACK	
CANCER		OSTEOPOROSIS	
HYPERLIPIDEMIA		CYSTIC FIBROSIS	
SICKLE CELL TRAIT		MENTAL RETARDATION	
AUTO IMMUNE DISORDERS		PULMONARY EMBOLISM/DVT	
ALZHEIMERS DISEASE		ANEMIA	
STROKE		OTHER	

Please list any surgeries or hospitalizations in the past _____

Current Medication

Drug Name _____ Who prescribed it? _____

Drug Name _____ Who prescribed it? _____

Are you allergic to any medications/latex? If so, please list them. _____

SOCIAL HISTORY

TOBACCO USE

Ever smoked? _____ Currently Smoking? _____ How many packs per day? _____

ALCOHOL USE

Drinks per day? _____ Per week? _____ Type? _____



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DRUG USE

Ever used drugs? _____ Currently? _____ Type? _____

Exercise Regularly? _____ Method _____ Amt. of calcium intake _____

Do you have a history of abuse? (Sexual, physical, verbal) _____

Do you PRESENTLY have any of the following? * Circle all that apply

Constitutional- Chills/fever, night sweats; fatigue, recent weight changes not related to dieting, change in appetite, other

Eyes, Ears, Nose, Throat- Vision changes, headaches, ulcers, sinusitis, other

Cardiovascular- Edema, palpitations, chest pain, difficulty breathing on exertion, other

Respiratory- shortness of breath, wheezing, cough, other

Gastrointestinal- Constipation, diarrhea, flatulence, bloody stool, abdominal pain, nausea/vomiting/indigestion, fecal incontinence, other

Genitourinary- Infertility, pelvic pain, abnormal bleeding, painful periods, abnormal discharge, painful intercourse, premenstrual syndrome(PMS), pain with urination, frequent urination, incontinence, incomplete emptying, blood in urine, other

Musculoskeletal- Muscle or joint pain, muscle weakness, other

Skin- Dry skin, rash, ulcers, pigmented lesions, ulcers, other

Breast- Discharge, masses, pain, other

Neurologic- Dizziness, seizures, numbness, trouble walking, other

Endocrine- Hot flashes, Heat/cold intolerance, excessive hair growth/loss, other

Hematologic/Lymphatic- Bruises, adenopathy, bleeding disorders, other

Patient signature _____ Date _____