Northwest GA Medical Clinic

15 Riverbend Dr., Suite 200 • Rome, GA 30161

HEALTH HISTORY

Name _____ Drug Allergies _____

Date _____ Current Pharmacy _____

Age _____ Race _____ Education _____ Occup. _____ Referring Dr. or Primary Care Dr. _____

Reason for Seeing Dr.: _____

Past Medical History / R.O.S.

	Patient Yes	Patient No	Family Yes	Family No
1. Headaches, nervous disorder, seizures, epilepsy _____	☐	☐	☐	☐
2. A thyroid problem _____	☐	☐	☐	☐
3. A heart condition or high blood pressure _____	☐	☐	☐	☐
4. A lung disorder or asthma _____	☐	☐	☐	☐
5. Breast problems _____	☐	☐	☐	☐
6. Jaundice, hepatitis, or other liver disorders _____	☐	☐	☐	☐
7. Stomach, bowel, or gallbladder problems _____	☐	☐	☐	☐
8. Kidney or bladder problems _____	☐	☐	☐	☐
9. Female or sexual problems _____	☐	☐	☐	☐
10. Anemia or blood disorders _____	☐	☐	☐	☐
11. A blood transfusion _____	☐	☐	☐	☐
12. Diabetes _____	☐	☐	☐	☐
13. Cancer, breast, ovary, colon, uterus, cervix _____	☐	☐	☐	☐
14. Birth defects or inherited diseases _____	☐	☐	☐	☐
15. Skin problems - rashes, change in moles, etc. _____	☐	☐	☐	☐
16. Any change in vision? _____	☐	☐	☐	☐
17. Anxiety, stress, mood changes _____	☐	☐	☐	☐
18. Other medical problems _____	☐	☐	☐	☐

19. Alcohol: Amount_____ Type _____
Tobacco: Amount_____ Type _____
Street Drugs: Amount_____ Type _____

20. Medications (*please list*)

_____

_____

_____

_____

Preventive Care

Date of Last: Physical _____

Pap Smear _____

Mammogram _____

PSA _____

Immunizations / Date:

Hepatitis _____

Influenza _____

Pneumovax _____

Tetanus _____

Menstrual History

Last Period ____/____/____

_____

Cycle _____

Length _____

Amount per heaviest day

Pads _____ Tampons _____

☐ Abnormal Bleeding

☐ Pain

☐ Menstrual Cramps

Family Planning

	Past	Pres
Oral contraceptive	☐	☐
IUD _____	☐	☐
Diaphragm _____	☐	☐
Tubal _____	☐	☐
Vasectomy_____	☐	☐
Depo Provera_____	☐	☐
Norplant_____	☐	☐

Other Problems:

Updates / Comments:

Hospitalizations (*please list*)

Mo/Yr	Illness or operation	Complications No	Complications Yes
/		☐	☐
/		☐	☐
/		☐	☐

Obstetrical History Please list the number of:

Times Pregnant _____ Premature Births _____

Miscarriages _____ Abortions _____ Living Children _____

No.	Born Mo/Yr	Weight at birth	Baby's sex	Weeks preg.	Type of delivery	Complications No	Complications Yes
1.	/	lb. oz.				☐	☐
2.	/	lb. oz.				☐	☐
3.	/	lb. oz.				☐	☐
4.	/	lb. oz.				☐	☐
5.	/	lb. oz.				☐	☐

Patient's Signature: