CFP Physicians Group

Today's Date: _____

MEDICAL HISTORY FORM

Patient Name: _____ Age: _____ D.O.B.: _____

Please share with us the reason for your visit: _____

_____

_____

PAST MEDICAL HISTORY	NO	YES	If yes, please explain		NO	YES	If yes, please explain
Cancer- Breast							
Cancer- Cervical				ID- Unusual Childhood Disease			
Cancer- Colon				Neurology- Headaches / Migraines			
Cancer- Lung				Neurology- Memory Loss / Dementia			
Cancer- Other				Neurology- Neuropathy			
Cancer- Ovary				Neurology- Other			
Cancer- Skin				Neurology- Seizures / Epilepsy			
Cancer- Prostate				Neurology- Stroke / TIA			
Cardiac- Heart Arrhythmia				Ortho- Chronic Back Pain			
Cardiac- Heart Disease				Ortho- Degenerative Joint Disease			
Cardiac- High Blood Pressure				Ortho- Fractures			
Cardiac- High Cholesterol				Ortho- Other			
Cardiac- Other				Psych- ADD			
Dermatology- Acne				Psych- Anxiety Disorder			
Dermatology- Eczema / Psoriasis				Psych- Bipolar Disease			
Dermatology- Other				Psych- Depression			
ENT- Hearing Loss				Psych- Eating Disorder			
ENT- Other				Psych- Other			
Endocrinology- Diabetes				Psych- PMS / PMDD			
Endocrinology- Osteopenia				Pulmonary- Asthma			
Endocrinology- Osteoporosis				Pulmonary- COPD / Emphysema			
Endocrinology- Other				Pulmonary- Other			
Endocrinology- Thyroid Problems				Pulmonary- Seasonal Allergies/Allergic			
Eyes- Cataracts				Pulmonary- Sleep Apnea			
Eyes- Glaucoma				Rheumatology- Arthritis			
Eyes- Other				Rheumatology- Autoimmune Disease			
Eyes- Vision Loss				Rheumatology- Fibromyalgia			
GI- Colon Polyps				Rheumatology- Other			
GI- Crohn's / Ulcerative Colitis				Rheumatology-Restless Leg Syndrome			
GI- Gallbladder Disease				Urology- Frequent Urinary Tract Infec			
GI- Hemorrhoids				Urology- Hematuria (Blood in Urine)			
GI- Irritable Bowel Syndrome				Urology- Interstitial Cystitis			
GI- Liver Disease / Hepatitis				Urology- Kidney Disease			
GI- Other				Urology- Kidney Infec			
GI- Reflux / Stomach Ulcers				Urology- Kidney Stones			
GI- Vitamin Deficieny				Urology- Other			
Hematology- Anemia				Urology- Urinary Incontinence			
Hematology- Bleeding Disorder				Wt Management- Obesity			
Hematology- Blood Clotting Disorder				Wt Management- Other			
Hematology- Blood Transfusion							
Hematology-DVT/Pulmonary Embolism							
Hematology-Other							
ID- HIV							
ID- MRSA							
ID- Other							
ID- Tuberculosis / Positive PPD							

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SURGICAL HISTORY *(Please list all procedures, not just OB-GYN)*

Date	Type of Surgery	Reason for Surgery

MEDICATIONS

Medication Name	Dose	Frequency

ALLERGIES / ADVERSE REACTIONS

Drug	What is your reaction?

GYN HISTORY *(please circle)* FEMALE ONLY

Frequency of Cycle:	Monthly	< 21 days	>35 days	very irreg.
Duration of flow in days:				
Amount of flow:	light	moderate	heavy	
Cramps:	no	yes		
Current birth control:	abstinence	condom	depo	essure
	IUD	nexplanon	patch	pills
	Ring	rhythm	tubal ligation	vasectomy
	none			
If applicable: Age at Menopause				
Sexual Orientation:	Heterosexual	Homosexual	Bisexual	
Sexually active:	yes	no		

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FAMILY HISTORY

Family Member	Medical Condition	Age at Diagnosis

SOCIAL HISTORY *(please circle)*

Smoking status:	never	former	daily	sometimes		
Smoking, how much?						
Alcohol intake:	none	occasional	moderate	heavy		
Illicit drugs?	none	yes				
Caffeine intake	none	occasional	moderate	heavy		
Exercise level:	none	occasional	moderate	heavy		
Diet:	regular/vegetarian	vegan	no gluten	cardiac	diabetic	
Marital status:	married	single	divorced	separated	widow	domestic partner
Hx of domestic violence:	yes	no				
Education:	<8th gr	8-12th	2 yr college	4 yr college	postgraduate	
Occupation:						
Religion:						
Seat belts used routinely?	yes	no				
Is a blood transfusion acceptable in an emergency?	yes	no				

PATIENT'S PHARMACY

Name	Address	Phone

PATIENT'S PROVIDERS *(Please list your primary doctor and any other doctors you see)*

Name	Specialty	Address & Phone Information