PREMIER SUBURBAN
MEDICAL GROUP

Patient Name: ____ DOB ____________________

Have YOU ever had:
(CIRCLE ALL THAT ARE YES)

Arthritis
Asthma/COPD/Emphysema
Anemia or blood transfusion
Blood clots
Cancer (where? _________)
Colon problems
Depression/Anxiety
Diabetes
GERD/esophageal reflux
Glaucoma
Gout
Heart attack
High blood pressure
High cholesterol
Kidney disease/stones
Liver disease
Migraines
Osteoporosis/osteopenia
Phlebitis/vein disease
Stroke
Thyroid problem
Abnormal Pap
Abnormal mammogram

Surgeries/Procedures
(CIRCLE ALL THAT ARE YES)

Appendix
Breast reconstruction
Breast lumpectomy
Bladder surgery
Cataract removal
Cesarean section

D & C
EGD (upper endoscopy)
Gallbladder
Gastric surgery
Heart valve replacement
Hysterectomy (ovaries Y/N?)
Joint replacement
Mastectomy R/L
Thyroid
Tonsillectomy
Transplant
Colonoscopy (Date/Where __________________)
Other procedures ___________________________________

Family History
(PLEASE STATE WHO HAD)

Alcoholism ________________________
Blood disease ______________________
Breast cancer ______________________
Colon cancer ______________________
Diabetes __________________________
Heart attack _______________________
High blood pressure _________________
High cholesterol ____________________
Mental illness ______________________
Migraines _________________________
Osteoporosis _______________________
Rheumatoid arthritis _________________
Other ____________________________

Other medical conditions/diseases not listed ____

Gynecologic History:
How old at first period? _____________ Last Period? ______________________
How long between periods? __________ How long do periods last? ___________________
Flow: Heavy / Normal / Light Cramps? Y / N
Times Pregnant? ______ Miscarriages _____ Abortions ______ Live Births _____
Birth Control: ____

Sexually Active? Yes No

Allergies: ____

Marital Status :___________________________ **Occupation** ________________________________

Medications:
____
____
_____

What are your health concerns? ____