Verdugo Internal Medicine
A Medical Group, Inc.
1809 Verdugo Boulevard
Suite 200
Donald W. Barber, M.D. 818-790-4730 Glendale, CA 91208 Victoria A. Altree, M.D. 818-790-1616
818-790-6225
818-790-2816 FAX

FEMALE MEDICAL HISTORY INFORMATION FORM

Patient Name:_____ **Birthdate:** _____ **Date:**_____

Born and raised in: _____

Patient's Past Medical History (Please Answer):

	Yes	No
Measles		
Mumps		
Chicken Pox		
Scarlet Fever		
Palpitations		
Angina		
Valvular Heart Disease		
Arrhythmias		
Hypertension		
Heart Failure		
Heart Attack		
Heart Murmur		
Strokes		
Seizures		
Migraines		
Depression or Anxiety		

	Yes	No
Bronchitis		
Asthma		
Emphysema		
Pneumonia		
Lung Cancer		
Tuberculosis		
Irritable Bowel Syndrome		
Hepatitis		
Crohn's Disease		
Ulcerative Colitis		
Diverticulosis		
Constipation		
Diarrhea		
Hemorrhoids		
Gallstones		
Anorexia or Bulimia		

	Yes	No
Hay Fever		
Sinusitis		
Glaucoma		
Thyroid Disease		
Diabetes		
Kidney Stones		
Kidney or Urine Infections		
Anemia		
Bleeding Disorder		
Back Pain		
Arthritis		
Rheumatic Fever		
Lupus		
Skin Problems		
Cancer		
Sexually transmitted disease		

List other medical history not noted above:

_____

List all surgeries with dates:

_____

_____

_____

_____

List all medications you are taking, including over the counter drugs:

Medication	Strength	Pills per Day	Date Medication Began

List any medications that you are allergic to or unable to tolerate and the reaction/side effect that you had with each:

Medication:	**Reaction or side effect**
_____	_____
_____	_____
_____	_____
_____	_____

List recent travel:

_____

_____

Family history:

Family Profile	**Living**	**Died**	**Age**	**Cause of Death**	**Other Diseases**
Paternal Grandfather					
Paternal Grandmother					
Maternal Grandfather					
Maternal Grandmother					
Father					
Mother					
Brothers					
Sisters					
Children					

Do you have a family history of any of the following diseases?

	Yes	No		Yes	No		Yes	No
Tuberculosis	___	___	Seizure	___	___	High Blood Pressure	___	___
Asthma	___	___	Migraine	___	___	Heart Attack Before Age 60	___	___
Hay Fever	___	___	Alcoholism	___	___	Stroke Before Age 60	___	___
Emphysema	___	___	Cirrhosis	___	___	Bleeding Disorder	___	___
Diabetes	___	___	Arthritis	___	___	Osteoporosis/Hip Fracture	___	___
Obesity	___	___	Early Senility	___	___	Hepatitis B or C	___	___
Thyroid Disease	___	___	Depression	___	___	Cancer/Leukemia	___	___

Personal Weight History:

Minimum Adult Weight: _____ Maximum (Non pregnant) Adult Weight: _____

Average Adult Weight _____

List your other doctors:

_____
_____
_____
_____
_____

Social History:
What is your occupation? _____ Do you enjoy your work? _____
Is it mildly, moderately or highly stressful? _____
Are you exposed to any chemicals, fumes, asbestos or toxins in your workplace? _____
Have you served in the military? If so, when and where:_____
Have you traveled out of the country? If so, when and where: _____

Are you single, married, divorced or widowed? _____ For how long? _____
If single, do you live with someone or have an ongoing relationship? _____
List your hobbies: _____
Do you exercise regularly? _____ How many times a week? _____
If so, what type of exercise? _____
Household pet(s) _____

Do you have a prior/present history of cigarette smoking? _____ How many packs per day? _____
How old were you when you started smoking? _____ Have you tried to quit? _____ If so, when? _____
Do you drink alcohol? _____ Do you drink coffee? _____
Do you have any prior/present history of drug abuse? _____
Are you on any special diet? _____

Ob-gyn history:
How many times have you been pregnant? ____ How many live births have you had? _____
How many miscarriages or abortions have you had? _____
Were any children delivered by Caesarian section? YES NO
Do you have a history of hypertension or preeclampsia during pregnancy? YES NO
Do you have a history of gestational diabetes? YES NO
Age of menstrual onset: _____ your cycle duration: _____days; amount of flow _____
What is the date of your last menstrual period? _____ How many days apart are your periods? _____
Are you aware of the toxic shock syndrome? YES NO Do you use tampons? YES NO
If sexually active, list the methods of birth control that you and your partner use _____
When was your last pap smear? _____ Was it normal? _____
Do you examine your breasts regularly? _____ When was your last mammogram? _____
Do you experience breast tenderness or lumps prior to your periods? YES NO
Do you take estrogen? _____ Do you take Calcium? _____

Please enter record of vaccinations:
Last Tetanus _____
Flu _____
Pneumonia Vaccine _____
Hepatitis B _____ _____ _____
Rubella _____ _____ _____
Shingles _____
Have you ever had an allergic reaction to any vaccine? _____

REVIEW OF SYSTEMS

Do you have a significant problem with any of the following symptoms?

Yes	No		Yes	No	
____	____	Fever	____	____	Difficulty Swallowing
____	____	Chills	____	____	Heartburn, nausea, or vomiting
____	____	Night Sweats	____	____	Abdominal Pain
____	____	Weight Loss	____	____	Indigestion
____	____	Weight Gain	____	____	Cramping
____	____	Heat Intolerance	____	____	Diarrhea
____	____	Cold Intolerance	____	____	Constipation
			____	____	Mucous in Stool
____	____	Excessive Bleeding	____	____	Blood in Stool
____	____	Rashes	____	____	Dark or Black Stool
____	____	Itching	____	____	Change in Bowel Habits
____	____	Lumps	____	____	Pain/Discomfort with Urination
____	____	Changes in Moles	____	____	Excessive or Frequent Urination
			____	____	Urge to Urinate
____	____	Headaches	____	____	Loss of Urine with Cough, Laughing or Sneezing
____	____	Change in Vision			
____	____	Blurry or Double Vision	____	____	Other Accidental Loss of Urine or Stool
____	____	Decrease in Hearing			
____	____	Noises in Ears			
____	____	Vertigo			
____	____	Frequent Bloody Noses	____	____	Abnormal vaginal bleeding
____	____	Nasal or Sinus Congestion	____	____	Abnormal vaginal discharge
____	____	Hoarseness	____	____	Pain with intercourse
____	____	Cough	____	____	Vaginal itching
____	____	Sputum	____	____	Breast tenderness
____	____	Bloody Sputum	____	____	Hot flashes
____	____	Shortness of Breath With Minor Exertion	____	____	Pain or Stiffness of Joints (list) _____
____	____	Chest Pressure	____	____	Back Pain
____	____	Chest Pain	____	____	Muscle Pain or Ache
____	____	Shortness of Breath When Lying Flat	____	____	Muscle Weakness
			____	____	Numbness in Arms or Legs
____	____	Unexplained Fatigue			
____	____	Ankle or Foot Swelling	____	____	Anxiety
____	____	Pounding or Skipping Heart	____	____	Depression
____	____	Lightheadedness	____	____	Difficulty Sleeping
____	____	Fainting	____	____	Loss of Appetite
____	____	Pain in Legs on Walking	____	____	Decreased Sex Drive

Any other information you feel relevant:

_____

_____