RIPON Family Physicians

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Medical History Form

Your answers on this form will help us understand your medical concerns and conditions better. If you are uncomfortable with any question, do not answer it.

Name_____ Date of Birth_____ Today's date_____

1. Personal Medical History

Please indicate if you have had any of the following problems currently or in the past.

Anemia	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Asthma/Emphysema	☐ Yes	☐ No	Kidney disease/stones	☐ Yes	☐ No
Chronic diarrhea/IBS	☐ Yes	☐ No	Liver disease/Hepatitis	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Lung disease/pneumonia	☐ Yes	☐ No
Diverticulosis	☐ Yes	☐ No	Pancreatitis	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Sexually transmitted disease	☐ Yes	☐ No
If yes, what age?_____			Sleep apnea	☐ Yes	☐ No
Epilepsy or Seizures	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Gallstones	☐ Yes	☐ No	Venereal disease/Syphilis	☐ Yes	☐ No
Gout	☐ Yes	☐ No	Thyroid disease/Goiter	☐ Yes	☐ No
Heartburn/Acid Reflux	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Tumors/Cancer	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No	Ulcers (stomach or intestinal)	☐ Yes	☐ No

If yes to any of the above, please explain_____

_____

_____

_____

_____

When was your last Tetanus shot given? _____

2. Family History ☐ **Adopted**, family history unknown.

Has anyone in your family (including grandparents, parents, brothers, sisters, or children) had any of the following conditions?

			Family Relationship:		
Bowel/Colon Cancer	☐ Yes	☐ No	_____	☐ Living	☐ Deceased at age_____
Breast Cancer	☐ Yes	☐ No	_____	☐ Living	☐ Deceased at age_____
Depression	☐ Yes	☐ No	_____	☐ Living	☐ Deceased at age_____
Diabetes	☐ Yes	☐ No	_____	☐ Living	☐ Deceased at age_____
Heart Disease	☐ Yes	☐ No	_____	☐ Living	☐ Deceased at age_____
High Blood Pressure	☐ Yes	☐ No	_____	☐ Living	☐ Deceased at age_____
High Cholesterol	☐ Yes	☐ No	_____	☐ Living	☐ Deceased at age_____
Kidney Disease	☐ Yes	☐ No	_____	☐ Living	☐ Deceased at age_____
Rheumatoid Arthritis	☐ Yes	☐ No	_____	☐ Living	☐ Deceased at age_____
Strokes	☐ Yes	☐ No	_____	☐ Living	☐ Deceased at age_____
Thyroid Disorder	☐ Yes	☐ No	_____	☐ Living	☐ Deceased at age_____
Other_____	☐ Yes	☐ No	_____	☐ Living	☐ Deceased at age_____

3. Personal Habits

Tobacco Use

Cigarettes: ☐ Never ☐ Former ☐ Current Smoker (Packs per day____ # of Years____ Quit-Date____)

Other tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Are you interested in quitting? ☐ Yes ☐ No

Alcohol Use

Do you drink alcohol? ☐ No ☐ Yes, average # of drinks per week_____

If no, have you in the past? ☐ Yes ☐ No

Drug Use

Do you use any recreational drugs, such as marijuana, cocaine, stimulants, narcotics, diet pills?

☐ No ☐ Yes (please circle which drugs)

Have you ever used needles? ☐ Yes ☐ No

Sexuality

Are you sexually active? ☐ Yes ☐ No ☐ Not currently

If sexually active, do you practice safe sex? ☐ Yes ☐ No

Birth control method________________

Have you ever had any sexually transmitted diseases (STD's)? ☐ Yes ☐ No

If yes, please include____

Exercise

Do you exercise regularly? ☐ Yes ☐ No How many times per week? _______________________

If yes, what type of exercises?____

Emotions

In the past year, have you had 2 weeks or more during which you felt sad, blue, or depressed; or when you lost interest or pleasure in things that you usually enjoyed? ☐ Yes ☐ No

4. Medications

Please list all your current medications, including medications and supplements not needing a prescription:
Or attach a complete list.

Medication	**Dose**	**Directions**	**Taken For:**	**Will our office be refilling?**
				☐ Yes ☐ No, refilled by specialist
				☐ Yes ☐ No, refilled by specialist
				☐ Yes ☐ No, refilled by specialist
				☐ Yes ☐ No, refilled by specialist
				☐ Yes ☐ No, refilled by specialist
				☐ Yes ☐ No, refilled by specialist
				☐ Yes ☐ No, refilled by specialist
				☐ Yes ☐ No, refilled by specialist
				☐ Yes ☐ No, refilled by specialist

5. Allergies

Please list any allergies or reactions to medications:

Medication	Reaction or Side Effect

6. Operations

Have you had any operations? If yes, list:

Type of operation / Reason for operation	Hospital / Facility	Date of operation

7. For Women Only

Total # of pregnancies_____ # of deliveries_____ # of miscarriages_____ # of abortions_____

Age at start of menstrual period _____

Date most recent menstruation began _____

Usual length of menstrual period _____ days

Date of last Pap smear _____

Have you ever had an abnormal Pap smear? ☐ Yes ☐ No

If yes, give date and describe_____

Have you stopped having menstrual periods? ☐ Yes ☐ No If yes, when_____

Do you have regular problems with:

Irregular, painful, or heavy menstrual periods ☐ Yes ☐ No

Bleeding between periods or after menopause ☐ Yes ☐ No

Vaginal discharge, pain or itching ☐ Yes ☐ No

Hot flashes ☐ Yes ☐ No

Pain or lumps in breasts ☐ Yes ☐ No

If you see a gynecologist for your annual exams, please list their name/phone: _____

Please return to:

Daryl R. Dutter, M.D., Inc.
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J. Jeffrey Daley, M.D.

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