

Patient Medical History Form

Name: _____ Date of Birth: _____ Age: _____

Reason for Visit Today: _____ Occupation: _____

Referred by: _____ PCP: _____ Marital Status: S M D

Medical History

Have you ever been treated for the following medical problems (please circle):

High Blood Pressure	Rheumatic Fever	Psychiatric Problems
Urinary Infections	Deep Vein Thrombosis	Ulcers
Migraines/Headaches	Heart Disease	Asthma
Breast Problems	Sidney Stones	Seizures
Hepatitis (Jaundice)	Heart Murmur	Stroke
Diabetes	Thyroid Disease	Ulcer

Other: _____

Have you ever been hospitalized: Yes No If yes, please list dates/locations and reasons:

Have you ever had any surgeries: Yes No If yes, list dates/procedures/locations and any complications:

Have you ever had a blood transfusion: Yes No If yes, what was the reason:

Allergies: _____

Current Medications: _____

Family History

Has anyone in your family had (please circle the following, if yes, list relationship/age)

Cancer: Breast _____ Uterine _____

Ovarian _____ Colon _____

Other _____

Blood Clotting Problems Heart Attack/Disease Osteoporosis

High Blood Pressure Thyroid Disease Diabetes

Stroke

Name: _____

Do you smoke: Yes No Do you drink: Yes No If yes, how many in an average week? _____

Do you use any recreational drugs: Yes No If yes, which ones: _____

Do you exercise regularly: Yes No

Do you have a history of domestic violence or sexual abuse: Yes No

Gynecological History

Have you ever had an abnormal pap smear: Yes No If yes, did you receive treatment: Yes No
If treated, please list dates and types of treatments?

Did your mother take DES when she was pregnant with you? Yes No

Date of Last Mammogram _____ Date of Last Pap Smear _____

Date of Last Bone Density _____ Age at Menopause _____

Have you ever been told that you have (please circle)

Endometriosis Ovarian Cysts Fibroids PMS (Premenstrual Syndrome)

Have you ever had any gynecological surgery: Yes No If yes please list the type of surgery

Have you ever had a sexually transmitted disease: Yes No If yes, please circle **all** that apply

Gonorrhea Chlamydia Trichomonas Genital Warts Syphilis Herpes PID

To your knowledge, have any of your partners had any of the above sexually transmitted diseases?

Yes No If yes, please list: _____

Have you ever had an abnormal mammogram Yes No Any Breast Problems Yes No

Are you on Hormone Replacement Therapy Yes No Please list: _____

Do you have problems with urination: Yes No If yes, circle all that apply

Loss of Urine Urinary Frequency Pain with Urination Other: _____

Menstrual History

Age of First Period _____ Number of day between periods _____

Number of days bleeding _____ Heavy Moderate Light

Do you have bleeding between periods: Yes No Age at first intercourse: _____

Do you have pain with intercourse: Yes No With your menstrual cycles: Yes No

Name: _____

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What form of birth control, if any are you using (please circle)

None Partner with Vasectomy Norplant Oral Contraceptive Withdrawal

Depo Provera Tubal Ligation Diaphragm Condoms IUD

Cervical Cap Spermicides Condoms Other: _____

Pregnancy History

Number of Pregnancies: _____ Ectopics: _____ Miscarriages: _____ Abortions: _____

Vaginal Deliveries: _____ Cesarean Section: _____ Complications: _____

Are there any concerns that you would like to discuss with the physician?

Signature

Date

Harmony Health Services

Consent for Communication Health Information to Personal Representatives

Name: _____

Address: _____

City, State, Zip Code

Telephone Number: _____

Date: _____

I, give my written consent for Harmony Health Services to share information regarding my protected Health Information (HIPAA) and care to the following listed person(s). I understand that these person(s) may be treated as personal representative(s) of myself.

Personal Representative(s) that you may share my health information with:

Name	Relationship	Telephone Number
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Name	Relationship	Telephone Number
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Name	Relationship	Telephone Number
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You may leave a message (please check all that apply)

_____ at home

_____ at work

_____ answering machine/voice mail

Verification Data: _____

Mother's Maiden Name

_____ City of Place of Birth

Patient's Signature

Date

Witness

PHARMACY VERIFICATION

NAME: _____

PHARMACY: _____

DATE: _____

The pharmacy that you have chosen above will be the pharmacy that all of your medications will be sent to.

If you decide to use another pharmacy, you will need to come in and sign a new form. No medications will be sent to a pharmacy other than the one you have on file with us.

Our policy is that all prescription refills require a 24 hour notice.

Please check with your pharmacy 24 hours after you have contacted our office for the refill. If the pharmacy does not have the prescription, please have the pharmacy call the office.

We only need one call for your prescription refill. We ask that you do not call our office multiple times.

Thank you.