CONFIDENTIAL
MEDICAL HISTORY FORM

Los Angeles Special Care Medical Associates

1/ NAME (last), (first): _____, _____ 2/ BIRTH-DATE: __/__/____

3/ REASON FOR VISIT: _____

_____

4/ MEDICAL / PSYCHIATRIC / SURGICAL HISTORY: TO THE BEST OF YOUR KNOWLEDGE, LIST ANY PREVIOUS DIAGNOSES, CHRONIC SYMPTOMATIC COMPLAINTS AND / OR SURGICAL PROCEDURE WITH CORRESPONDING DATES (I.E. WHEN FIRST DIAGNOSED, SYMPTOMS WERE FIRST NOTED AND/OR UNDERWENT SURGERY)

☐ <-- check here if NONE, then move to #5.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

ENTER DATES IN (m/yy) FORMAT

5/ IN DESCRIBING YOURSELF, PLEASE INDICATE A RESPONSE TO THE FOLLOWING (OPTIONAL):

SEXUAL IDENTIFICATION: _____ SEXUAL ORIENTATION: _____

PARTNERSHIP STATUS: _____ RACE/ETHNICITY: _____

6/ FEMALES ONLY: ☐ <--check here if this section does NOT apply to you, then move to #7

Date of last menstruation (m/d/yy): _____ age when periods first began _____ Are periods regular? _____

Menstruation pattern _____ total # of pregnancies= _____ # of live births: ____ miscarriages: ____ abortions: ____

Last PAP (M/D/YY): _____ Any history of abnormal paps? _____ Any history of abnormal mammograms? _____

Any personal / family history of breast cancer? ☐ NO ☐ Yes, diagnosed at age: ____ ☐ Yes, in parent or sibling How often do you do self-breast exams? _____

7/ CURRENT MEDICATIONS, strength & dosing frequency (PLEASE SHOW THEM TO THE MEDICAL ASSISTANT OR NURSE): ☐ <-- Check here if none, then move to #8

--> _____ --> _____ --> _____

--> _____ --> _____ --> _____

8/ ANY KNOWN DRUG OR FOOD ALLERGIES? ☐ <-- Check here if NONE then move to #9.

_____

9/ ANY HISTORY OF HEART DISEASE, DIABETES, HIGH CHOLESTEROL, PSYCHIATRIC ILLNESS,CANCER, HIGH BLOOD PRESSURE OR OTHER SIGNIFICANT MEDICAL PROBLEMS IN YOUR FAMILY? (PERTAINING TO PARENTS, SIBLINGS OR CHILDREN ONLY.)

☐ <-- Check here if NONE, then move to #10 _____

_____

10/ SOCIALLY OR OTHERWISE, DO YOU...

1/DRINK ALCOHOL? _____ 2/SMOKE CIGARETTES/CIGARS? _____

3/USE RECREATIONAL DRUGS? _____ 4/USE IV DRUGS? _____

11/ DO YOU HAVE ANY QUESTIONS OR WOULD YOU LIKE SOME INFORMATION ON....

A/ SAFER SEX? ○ YES ○ NO B/ ADVANCED DIRECTIVES? ○ YES ○ NO

12/ ACKNOWLEDGEMENT: "I confirm that the information included on this form was provided directly by the person stated below:"

CLIENT NAME (last),(first): _____, _____

Signature: _____

DATE SIGNED: _____