ROBERT E. FORD, M.D.
FAMILY PRACTICE

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MEDICAL HISTORY

NAME:_____ SS#_____ DATE_____

DO YOU CURRENTLY HAVE *OR* HAVE YOU HAD ANY OF THE FOLLOW DISORDERS:

Y N High blood Pressure
Y N Bleeding Disorder
Y N Blood Clots
Y N Heart Disease
Y N Thyroid Disease
Y N Seizure Disorder
Y N Tuberculosis
Y N Lung Disease
Y N Rheumatic Fever
Y N Breast Problems
Y N Sexually Transmitted Disease
Y N Psychiatric Disorder
Y N Bladder/Kidney Disease
Y N Circulation Problems
Y N Liver/Gall Bladder Disease
Y N Drug/Alcohol Addiction
Y N Sickle Cell Disease
Y N Gynecology Disease
Y N High Cholesterol
Y N Depression
Y N Hepatitis
Y N Cancer
Y N Diabetes
Y N Ulcers
Y N Stroke
Y N Arthritis
Y N Anemia
Y N AIDS/HIV
Y N Other _____

PLEASE LIST ALL SURGERIES AND DATES: _____

_____

_____

PLEASE LIST CURRENT MEDICATION:

_____ _____
_____ _____
_____ _____
_____ _____

MEDICATION ALLERGIES:

_____
_____
_____
_____

HAS ANY IMMEDIATE FAMILY MEMBER HAD:

Y N Heart Disease
Y N Diabetes
Y N Cancer
Y N Stroke

DO YOU USE:

Y N Tobacco Products
Y N Alcohol
Y N Recreational Drugs

FEMALES ONLY

First day of last menstrual period _____
Number of days b/w periods _____
Flow ☐ light ☐ moderate ☐ heavy
Age at menopause _____
Number of pregnancies _____
Number of deliveries _____
Number of abortions _____

Periods ☐ normal ☐ abnormal
Number of days of flow _____
Age at first period _____
Last PAP _____ ☐ normal ☐ abnormal
Any complications _____
Type of deliveries _____
Number of miscarriages _____