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

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 _____