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PATIENT MEDICAL HISTORY

To help us meet all your healthcare needs, please fill out this form completely. This is a confidential record of your medical history and will be kept in this office.

Patient Name _____ Birthdate ____/____/____ Age _____

Today's date: ____/____/____ Date of last physical exam? ____/____/____

I. PAST MEDICAL HISTORY — Have you ever had the following:

- | | | |
|---------------------------|---------------------------------|------------------------------|
| — last Pap smear _____ | — Irritable Bowel Disease _____ | — Kidney Problems _____ |
| — last Colonoscopy _____ | — Hepatitis _____ | — Stroke _____ |
| — last Mammogram _____ | — PMS _____ | — Bladder Infections _____ |
| — last Bone Density _____ | — Stomach Ulcers _____ | — Radiation Therapy _____ |
| — Anemia _____ | — Herpes _____ | — Skin Cancer _____ |
| — Endometriosis _____ | — Arthritis _____ | — Genital Warts _____ |
| — Seizure _____ | — Hypertension _____ | — Depression _____ |
| — Cancers _____ | — Bone Fractures _____ | — Leg/Lung blood clots _____ |
| — Heart Disease _____ | — Headaches _____ | — STD _____ |
| — Uterine Fibroids _____ | — Sickle Cell Anemia _____ | — Asthma _____ |
| — Thyroid Disease _____ | — Osteoporosis _____ | — any other disease _____ |
| — Diabetes _____ | — Pneumonia _____ | |
| — Abnormal Pap _____ | — Transfusions _____ | |

Patient denies any PMH

2. PAST SURGICAL HISTORY — Have you ever had the following:

Denies any surgeries

- | | | |
|---|--|--|
| <input type="checkbox"/> Hysterectomy _____ | <input type="checkbox"/> C-Section _____ | <input type="checkbox"/> D&C _____ |
| <input type="checkbox"/> Appendix _____ | <input type="checkbox"/> Gallbladder _____ | <input type="checkbox"/> Breast Biopsy _____ |
| <input type="checkbox"/> Tonsil _____ | <input type="checkbox"/> Knee Surgery _____ | <input type="checkbox"/> Laparoscopy _____ |
| <input type="checkbox"/> Cosmetic _____ | <input type="checkbox"/> Tubal Sterilization _____ | <input type="checkbox"/> Other Surgeries _____ |

Please list all serious illnesses and operations you have experienced and indicate year occurred

3. MEDICATIONS: Please list all medicines you are currently taking, including dosage and how often per day:

Current Medications	Dosage (mg)	How often per day?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Denies any Medications

4. Please list all ALLERGIES (food, drugs, and environment)

Denies any Allergies

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PATIENT MEDICAL HISTORY (continued)

5. FAMILY HISTORY: Has any blood relative had any of the following: (leave blank if uncertain)

Denies family history of Breast Cancer Colon Cancer GYN Cancer

Relationship

Cancer _____

Type _____

Diabetes _____

Type _____

Heart Disease _____

Osteoporosis _____

Genetic Problem _____

High Blood Pressure _____

Seizure Disorder _____

Stroke _____

Kidney Problems _____

Leg/Lung Blood _____

6. MENSTRUAL HISTORY

Age of 1st period _____ Days between period _____ Flow: Light Medium Heavy Clots

Total days on period _____ Last Period _____ Method of Birth Control _____

Menopausal: Yes/No Age Menopause # _____ Breakthrough bleeding: Yes/No Hormone Replacement Therapy: Yes/No

7. PREGNANCY:

Total pregnancy # _____ Full Term # _____ Premature# _____ Ectopic # _____ Terminated # _____

Miscarriages # _____ Multiple # _____ Living # _____

Pregnancy details:

Birthdate	Weight	Gender	Type of Delivery	Complications	Location

8. SOCIAL HISTORY

Smoking (type & amount) _____

If former smoker, date quit _____

Alcohol (type & amount per week) _____

Street drugs (type & amount per day) _____

Occupation _____

Marital Status _____