flash gordon md ● 1000 S. Eliseo Dr. #204 ● Greenbrae CA 94904 ● 415.461.2262 vox, 461.9376 fax

MEDICAL HISTORY

This information is part of your **private** *medical record, and is* **confidential** *and* **protected by law**. Rev 20110205

Print name M☐ F☐	DOB	Today's date

Single☐ Partnered☐ Married☐ Separated☐ Divorced☐ Widowed☐ Other☐→

Occupation:

Previous doctor→	Last physical→	How did you find our practice→

PERSONAL HEALTH HISTORY

Past illnesses Measles☐ Mumps☐ Rubella☐ Rheumatic Fever☐ Polio☐

List all past and present medical problems (high blood pressure, diabetes, depression, cancer, etc.) None☐

Surgeries and hospitalizations None☐

Year	Problem	Hospital	Doctor (if known)

Have you ever had a blood transfusion? Yes☐ No☐ If so, what year→

Medications / vitamins / supplements / None☐

List all your prescribed and over-the-counter drugs, vitamins, supplements, herbs, etc.

Allergies to medications and other sensitivities None☐

Name	Reaction you had

Reviewer initials

HEALTH HABITS and **PERSONAL SAFETY**		
Exercise	None☐ Rare☐ Occasional☐ Regular☐ Details→	
Diet	Are you dieting? Yes☐ No☐ Details→	
	Meals per day→ Salt intake High☐ Med☐ Low☐ Fat intake High☐ Med☐ Low☐	
Caffeine	None☐ Coffee☐ Tea☐ Cola☐ Other☐→ How many per day→	
Tobacco	None☐ Cigarettes – packs/day→ Chew☐#/day→ Pipes☐/day→ Cigars☐/day→	
	number of years→ If you quit, when and why→ Never smoked☐	
Alcohol	If you drink, how many drinks do you **average**?→	
	How many days per month do you drink **at all**?→	
	How many drinks **maximum** have you had in 2 hours?→	
	How many times have you drunk that much **in the last year**? →	
	How many times have you drunk that much in 2 hours **in your life**?→	
	Have you ever felt you should **cut down** on your drinking?	Yes☐ No☐
	Have people **annoyed** you by criticizing your drinking?	Yes☐ No☐
	Have you ever felt bad or **guilty** about your drinking?	Yes☐ No☐
	Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (an "**eye-opener**")?	Yes☐ No☐
Other Drugs	Do you currently use recreational or street drugs (besides marijuana)?	Yes☐ No☐
	Have you ever given yourself street drugs with a needle?	Yes☐ No☐
Sex	Are you sexually active (partner/s, spouse/s)?	Yes☐ No☐
	Have you had unprotected sex?	Yes☐ No☐
	Are you trying for a pregnancy?	Yes☐ No☐
	Contraception? (i.e., BC pill; same sex partner; partner sterilized, etc.)→	
	Do you have concerns about HIV or other sexually transmitted diseases?	Yes☐ No☐
	Any discomfort or problems with intercourse?	Yes☐ No☐
Safety	Do you live alone?	Yes☐ No☐
	Have you fallen in the last year?	Yes☐ No☐
	Do you have vision or hearing loss?	Yes☐ No☐
	Have you been a victim of emotional, physical or verbal abuse?	Yes☐ No☐
	Do you have an Advance Directive or Living Will? If so, where is it?	Yes☐ No☐

MENTAL HEALTH		
When good things happen, are you happy? Yes☐ No☐	Have you been treated for depression? Yes☐ No☐	Have you attempted to commit suicide? Yes☐ No☐
Do you panic and "lose it" if stressed? Yes☐ No☐	Is it hard to **fall** asleep? Yes☐ No☐ Is it hard to **stay** asleep? Yes☐ No☐	Do you feel depressed, down, hopeless or sad? Yes☐ No☐
Do you have eating, appetite, or weight problems? Yes☐ No☐	Do you use sleeping pills more than twice a week? Yes☐ No☐	Do you enjoy life a lot less than in the past? Yes☐ No☐
Do you have bipolar, alcoholic or suicidal relatives? Yes☐ No☐	Has stress or anxiety affected your work, relationships or happiness? Yes☐ No☐	Do you feel jittery, short of breath, or feel your heart racing? Yes☐ No☐
Do you sometimes have so much energy you don't need sleep like usual? Yes☐ No☐	Do you have periods of high energy, followed by low energy periods? Yes☐ No☐	Do you now see a therapist, or have you seen one in the past? Yes☐ No☐
Have you been hospitalized for emotional or mental health problems? Yes☐ No☐	Have you experienced something so bad you had nightmares, or thought about it when you don't want to? Yes☐ No☐	Do you ever feel afraid that you may be "losing it?" Yes☐ No☐
Have you had thoughts of hurting yourself? Yes☐ No☐	Have you had thoughts of hurting someone else? Yes☐ No☐	Do you have any other mental health concerns? Yes☐→No☐

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FAMILY HEALTH HISTORY

rev. 11/12/7

Circle L=Living or **D=dead** ↓	**Age** now or at death ↓	Health **problems** and cause of death ↓	**Circle L=Living** or **D=dead** ↓	**Age** now or at death ↓	Health **problems** and cause of death ↓
Father **L/D**			Children **L/D**	M☐ F ☐	
Mother **L/D**			**L/D**	M☐ F ☐	
Brothers, Sisters **L/D**	M☐ F ☐		**L/D**	M☐ F ☐	
L/D	M☐ F ☐		**L/D**	M☐ F ☐	
L/D	M☐ F ☐		Mom's mother **L/D**		
L/D	M☐ F ☐		Mom's father **L/D**		
L/D	M☐ F ☐		Dad's mother **L/D**		
L/D	M☐ F ☐		Dad's father **L/D**		

PREVENTION (***relative = mom, dad, sibling, child, aunt, uncle, grandparent or* their *relative***)	
Has a relative had **breast cancer?** Yes☐ No☐ **A**ge? _____ Did they die from that problem?	Yes☐ No☐
Has a relative had **colon cancer**? Yes☐ No☐ Age? _____ Did they die from that problem?	Yes☐ No☐
Has a relative had **heart disease/stroke?** Yes☐ No☐ **A**ge? _____ Did they die from that problem?	Yes☐ No☐
Have you had a colonoscopy or sigmoidoscopy? When? ___________	Yes☐ No☐
Have you had your **cholesterol** checked? Yes☐ No☐ Was it elevated?	Yes☐ No☐
Do you see a **dentist** at least annually?	Yes☐ No☐
Do you get an **eye exam** annually?	Yes☐ No☐
What's your **lowest** and **highest** adult weight?_____ /______ At what age? _____ /_____	Yes☐ No☐
When was your last tetanus shot? ______ Did it include whooping cough vaccine?	Yes☐ No☐
Have you had a **flu shot** in the last 12 months? When?	Yes☐ No☐
Have you ever had **chickenpox** (varicella) **or** the **chickenpox** vaccine?	Yes☐ No☐
Have you had the **pneumonia vaccine**?	Yes☐ No☐
Have you had **hepatitis B vaccine**?	Yes☐ No☐
Have you had **shingles** or the **shingles** vaccine?	Yes☐ No☐
Do you feel fully **refreshed** when you wake up (not tempted to go back to sleep)?	Yes☐ No☐
Have you been screened for **skin cancer**?	Yes☐ No☐
Do you use **sunscreen**?	Yes☐ No☐
Do you take **calcium** *citrate* and vitamin D? Amount→	Yes☐ No☐
Do you always wear a **seatbelt** while in a car, taxi, or shuttle?	Yes☐ No☐
Do you always wear a **helmet** on a bicycle or motorcycle?	Yes☐ No☐
Do you have working **smoke detectors** at home?	Yes☐ No☐
Are **chemicals, poisons, medications**, and **firearms** out of kids' reach at home?	Yes☐ No☐
If you **smoke**, do you know that **beta-carotene** pills may be dangerous?	Yes☐ No☐
Do you take **both vitamin C** *and* **vitamin E**?	Yes☐ No☐

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MEN ONLY	
Date of last prostate exam?	
Do you get up to urinate at night? How often? __________	Yes☐ No☐
Have you ever had pain or burning when you urinate? Yes☐ No☐ **A**ge? _____ Do you have it now?	Yes☐ No☐
Have you ever had blood in your urine? Yes☐ No☐ **A**ge? _____ Do you have it now?	Yes☐ No☐
Have you ever had a discharge from your penis? Yes☐ No☐ **A**ge? _____ Do you have it now?	Yes☐ No☐
Has the force of your urination decreased?	Yes☐ No☐
Have you had a kidney, bladder, or prostate infection in the last year?	Yes☐ No☐
Do you have problems emptying your bladder completely?	Yes☐ No☐
Any problems with leaking, urgency or frequency of urination?	Yes☐ No☐
Do you have difficulty with erection or ejaculation?	Yes☐ No☐
Do you have any testicle pain, swelling, or lumps?	Yes☐ No☐

WOMEN ONLY	
Date of last pelvic exam→ By whom→ Last mammogram date→	
Date of last bone mineral density test → Did it show a problem? →	Yes☐ No☐
Heavy periods, irregularity, spotting, pain, or discharge?	Yes☐ No☐
Are you pregnant or breastfeeding **now**?	Yes☐ No☐
Any urinary blood, bladder or kidney infections in the last year?	Yes☐ No☐
Any problems with leaking, urgency or frequency of urination?	Yes☐ No☐
Do you get bladder infection symptoms and **not** have an infection found when your urine's checked?	Yes☐ No☐
Do you have tension, pain, bloating, irritability or other symptoms around your period?	Yes☐ No☐
Do you have hot flashes or sweating at night?	Yes☐ No☐
Do you have any problem with sexual function?	Yes☐ No☐
Have you had the Gardisil® vaccination against human papilloma virus (HPV)?	Yes☐ No☐
Have you had breast tenderness, lumps, or nipple discharge?	Yes☐ No☐
Have you ever had a breast biopsy? If so, when? Result?	Yes☐ No☐
Are you confident in doing your breast self-exam? Yes☐ No☐ Would you like information on this?	Yes☐ No☐
Have you had a D&C, hysterectomy, or Cesarean?	Yes☐ No☐
If sexually active, do you take a multivitamin with folic acid daily?	Yes☐ No☐

OTHER SYMPTOMS

Check Yes☐ if you've had **significant** problems in these areas. Otherwise, check No☐. (If not sure, check Yes☐☽.

Skin (rash, moles, skin cancer) Yes☐ No☐	Heart (chest pain/pressure, palpitations, shortness of breath) Yes☐ No☐	Chest/breast (lump, nipple discharge) Yes☐ No☐
Lungs (cough, cancer, wheeze, breathing, asthma, TB) Yes☐ No☐	Muscles/Bones/Back (pain, stiffness, joint replacement, fractures) Yes☐ No☐	Ears (change in hearing, ringing in ears, ear pain) Yes☐ No☐
Blood (unexplained lumps or lymph nodes, anemia, bruising/bleeding, hemophilia) Yes☐ No☐	Gastrointestinal (abdominal pain, jaundice, change in stool, nausea, vomiting, diarrhea) Yes☐ No☐	Neuro (headache, dizziness, stroke, memory loss, seizure, confusion) Yes☐ No☐
Nose (hay fever, allergies, nosebleeds, change in sense of smell, sinus infections) Yes☐ No☐	Body (fever, chills, sweats, excessive thirst or urination, unexplained weight gain/loss, fatigue, weakness) Yes☐ No☐	Eyes (change in vision, glasses, contact, cataracts, eye surgery) Yes☐ No☐
Throat (swallowing problems, sore throat, voice change) Yes☐ No☐	Limbs (cramps when walking, pain, tingling, weakness) Yes☐ No☐	Circulation (cold, blue, or numb hands or feet) Yes☐ No☐

Please **print** your name ____ DOB __________________
Signature ____

✔ Reviewer initials