California Women's Medical Clinic
Michael C Wong, M.D.

HISTORY MRN#

NAME: DATE OF BIRTH: DATE:

MARITAL STATUS: PHONE (H): PHONE (W):
❑S ❑M ❑W ❑D ❑SEP.

OCCUPATION/EMPLOYER: SS#: INSURANCE#:

FAMILY HISTORY — IF ANY BLOOD RELATIVE HAS SUFFERED ANY OF THE FOLLOWING, PLEASE CIRCLE THE NUMBER & INDICATE WHICH RELATIVE

1) ALCOHOLISM	6) CANCER	11) HEART DISEASE	16) OSTEOPOROSIS
2) ANEMIA	7) DIABETES	12) HYPERTENSION	17) STROKE
3) ASTHMA	8) EPILEPSY	13) KIDNEY DISEASE	18) THYROID
4) ARTHRITS	9) GLAUCOMA	14) MENTAL ILLNESS	19)
5) BLEEDS EASILY	10) HAYFEVER	15) MIGRAINE	20)

HOSPITAL: ILLNESS OR OPERATION:

YEAR:

ADMISSIONS:

(not including pregnancies)

ALLERGIES:

PAST:

PRESENT:

LIST ALL MEDICATIONS YOU ARE NOW TAKING:
(Including Over the Counter)

1)	7)
2)	8)
3)	9)
4)	10)
5)	11)
6)	12)

VACCINE (Date of last)	**TEST/EXAM** (Date of Last)
Tetanus' Diphtheria	Cholesterol
Influenza	Dental
Pneumococcal	Eye
Hepatitis	Hearing
	Rectal/Stool
	Sigmoidoscopy
	Tuberculosis Skin Test

SYNOPSIS: **(office use only)**

MEDICAL **1)** **2)** **3)**

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HISTORY

MAIN PROBLEMS _____

Check (✓) and indicate age when you had any of the following symptoms or diseases.
MARK (✖) for current problems.

- ❑ Decreased Hearing
- ❑ Ringing in Ear
- ❑ Ear Infections – *frequent*
- ❑ Dizzy Spells
- ❑ Failing Vision ❑ Eye Pain
- ❑ Double or Blurred Vision
- ❑ Eye Infections – *frequent*
- ❑ Nose Bleeds – *recurrent*
- ❑ Sinus Trouble
- ❑ Sore Throats – *frequent*
- ❑ Hayfever/Allergies
- ❑ Hoarseness – *prolonged*
- ❑ Pneumonia/Pleurisy
- ❑ Bronchitis/Chronic Cough
- ❑ Asthma/Wheezing
  Shortness of Breath:
- ❑ on Exertion ❑ Lying Flat
- ❑ Chest Pain
- ❑ High Blood Pressure
- ❑ Heart Murmur
- ❑ Irregular Pulse
- ❑ Palpitations
- ❑ Swollen Ankles
- ❑ Fainting Spells
- ❑ Leg Pain – *Walking*
- ❑ Varicose Veins/ Phlebitis
- ❑ Loss of Appetite – *recent*
- ❑ Difficulty Swallowing
- ❑ Indigestion or Heartburn
- ❑ Peptic Ulcers
- ❑ Abdominal Pain – *Chronic*
- ❑ Gall Bladder Trouble
- ❑ Jaundice/Hepatitis
- ❑ Change in Bowel Habits
- ❑ Diarrhea ❑ Constipation
- ❑ Crohn's/ Colitis
- ❑ Bloody or Tarry Stools
- ❑ Hemorrhoids
- ❑ Hernia
- ❑ Urine Infections – *frequent*
- ❑ Blood in Urine
  Urination ❑ Overnight > twice
  ❑ Painful ❑ Loss of Control
  ❑ Decrease in Force/Flow
- ❑ Kidney Stones
- ❑ Venereal Disease
- ❑ Urethal Discharge
- ❑ Chronic Fatigue
- ❑ Weight Loss – *recent*
- ❑ Anemia ❑ Bruise Easily
- ❑ Cancer
- ❑ Diabetes
- ❑ Thyroid Disease
- ❑ Convulsions/Seizures
- ❑ Stroke
- ❑ Tremor/Hands Shaking
- ❑ Muscle Weakness
- ❑ Numbness/Tingling Sensations
- ❑ Headaches – *frequent*
- ❑ Arthritis/Rheumatism
- ❑ Back Pain – *recurrent*
- ❑ Bone Fracture/Joint Injury
- ❑ Gout
- ❑ Osteoporosis
- ❑ Foot Pain
- ❑ Cold Numb Feet
- ❑ Rashes
- ❑ Hives
- ❑ Psoriasis
- ❑ Eczema
- ❑ Sleeping – *difficulty*
- ❑ Nervousness
- ❑ Depression
- ❑ Memory Loss
- ❑ Moodiness – *excessive*
- ❑ Phobias
- ❑ Mental Illness
- ❑ Chicken Pox
- ❑ Polio
- ❑ Mumps
- ❑ Measles
- ❑ German Measles
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Tuberculosis
- ❑ Herpes
- ❑ Contact with Blood or Body Fluids
- ❑ Alcohol
  _____ oz. per week
- ❑ Smoking
  _____ cig. per day
  Number of years _____
- ❑ Coffee / Tea
  # of cups per day _____
- ❑ Advanced Directives

MALES – Please Complete

Date of last prostate exam
❑ Normal ❑ Abnormal

Date of Last PSA_____

FEMALES – Please Complete

Menstrual Flow:
❑ Regular ❑ Irregular
❑ Pain/Cramps
Days of Flow _____
Lenghts of Cycle _____
Date _____ of last period _____
❑ Pain / Bleeding during or after sex
Number of:
_____ Pregnancies
_____ Abortions
_____ Miscarriages
_____ Live Births
Birth Control Method: _____
Birth Control Pill (Name): _____
❑ Flushing / Menopause
Date of Last pelvic exam: _____
Date of last PAP test: _____
❑ Normal ❑ Abnormal
Date of Last Breast Exam: _____
Date of Last Mamogram: _____
❑ Normal ❑ Abnormal

Patient's Signature: _____ Date: _____

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