Mt Lebanon Internal Medicine
300 Cedar Blvd., Pittsburgh, PA 15228
(412) 561-1484; FAX (412) 561-7145

Medical History

Name: _____ Age: _____ Birth date: _____
Single☐ Married☐ Divorced☐ Widowed☐ Separated☐ Spouse name: _____
Children (ages): _____
Occupation: _____
Education: _____

Allergies to medications, X-ray contrast, or other substances (please list the name of medicine and type of reaction):

_____
_____
_____

Medications (Prescription, over-the-counter, vitamins, dietary supplements, etc.)

Drug name	Dose	Frequency	Drug name	Dose	Frequency

Past Medical History
Please list medical problem, year of occurrence, treatment, including hospitalizations, and operations:

_____
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MD Review_____ Date: _____

Gynecologic and Obstetric History

Name of Gynecologist (if you are seeing one): _____
Age at onset of periods: _____ Frequency: _____ Length of period: _____
Pregnancies: _____ Births: _____ Miscarriages: _____ Abortions: _____
Age of menopause: ____ Symptoms of menopause: _____
Date of last period: _____ Method of birth control: _____
Do you take, or have you ever taken, hormone replacements or birth control pills? _____
Describe: _____
Have you had other gynecologic problems? _____ Describe: _____
Last Mammogram: _____
Last Pap Smear: _____
Last DEXA (bone density) scan: _____

Family History

Family member	Living?	Age	Cause of Death	Other Illnesses
Grandparents				
Father				
Mother				
Siblings				
Children				

Prevention

Last Sigmoidoscopy or Colonoscopy: _____
Do you take aspirin regularly? _____ How much? _____
Do you take calcium regularly? _____ How much? _____
Last Flu shot (influenza): _____
Pneumonia shot (Pneumovax): _____
Meningococcus Meningitis vaccine (Menomune): _____
Last Tetanus shot: _____
Have you had the Hepatitis B series of shots? _____ When? _____
Do you have an Advance Directive, Living Will, etc.? ____ If so, we would like a copy to keep in your medical record.
Do you have an organ donor card? _____
Do you smoke? _____ How much? _____
Do you drink alcohol? _____ How much? _____
Do you use any recreational drugs? _____ Which? _____
What exercise do you do?_____
Do you wear a seatbelt? _____
Do you wear sunscreen when out in the sun? _____