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ADULT HISTORY

Date Completed _____ Date of Birth _____

| Have you ever had: | | |
|--------------------|----|--------------------------------|
| Yes | No | |
| | | Smoking |
| | | Diabetes |
| | | High blood pressure |
| | | A heart murmur |
| | | Heart trouble |
| | | Heart attack |
| | | High cholesterol |
| | | Seizures |
| | | Stroke |
| | | Asthma |
| | | Emphysema |
| | | Hay fever/sinus problem |
| | | Pneumonia |
| | | Ulcers |
| | | Hepatitis |
| | | Thyroid Problem |
| | | Arthritis |
| | | Anemia |
| | | Sexually transmitted infection |
| | | Urinary infection |
| | | Cancer |
| | | Breast lump |
| | | Abnormal PAP smear |
| | | Drug or alcohol abuse |
| | | Depression |

| ALLERGIES OR SEVERE REACTIONS TO MEDICATION OR FOOD | | |
|---|------------------|----------------|
| <input type="checkbox"/> NONE | | |
| Medication/food | Year of Reaction | What happened? |
| | | |
| | | |
| | | |
| | | |

| MEDICATIONS CURRENTLY TAKEN <input type="checkbox"/> NONE | | |
|---|-----------|-----------|
| Medication | How Often | What for? |
| | | |
| | | |
| | | |
| | | |

| CHRONIC ILLNESS, SURGERY AND HOSPITALIZATIONS (Do not include emergency room visits or childbirth) | |
|---|-------------------------------|
| Year | Why hospitalized/what surgery |
| | |
| | |
| | |
| | |

| STATEMENTS DESCRIBING YOUR USE OF MEDICATIONS: (Check one or more) |
|--|
| <input type="checkbox"/> Buy medication on my own to treat myself |
| <input type="checkbox"/> Never take medications unless prescribed |
| <input type="checkbox"/> Usually want a medication prescribed for my illness |
| <input type="checkbox"/> Willing to try non-drug treatments |
| <input type="checkbox"/> Strongly prefer non-drug treatments |
| <input type="checkbox"/> Never take drugs or only as last resort |

MENSTRUAL HISTORY

Age periods began _____

Spacing of periods _____
 (No. of days from first day of one to first day of next)

Duration _____
 (No. of days of bleeding)

Amount of flow Light
 Moderate
 Heavy

Age periods stopped _____

BIRTH CONTROL
 (check the statement which applies)

Use birth control currently
 Which method? Condoms
 Birth control pills
 Other: _____

Do not use birth control

OBSTETRICAL HISTORY

Number of times pregnant _____

Number of full term babies _____

Number of premature babies _____

Number of abortions or miscarriages _____

Number of living children _____

Number of stillborn babies _____

HEALTH SCREENING AND PREVENTION

What was the year of your last:

Tetanus shot _____

Blood pressure measurement _____

Cholesterol test _____

Colonoscopy _____
 (tube inserted into the rectum to screen colon cancer)

WOMEN ONLY:

Pap smear _____

Mammogram (x-rays of the breast) _____

Breast exam by medical practitioner _____

Bone density test _____

SMOKING HISTORY

Smoking cigarettes currently:
 Packs/day _____
 Year started _____

Stopped smoking cigarettes
 Year started _____
 Year stopped _____
 Packs/day when smoked _____

Smoke pipe or cigars currently

Smoked pipe or cigars in past

Never smoked

ALCOHOL USE

Do not drink alcohol currently

Currently do drink (even occasionally)
 How often:
 Less than 1 drink/month
 1-3 drinks/month
 1-3 drinks/week
 1-3 drinks/day

How many drinks do you have at one time?
 1 or 2 drinks
 3 or 4 drinks
 5 or more drinks

(One "drink" = one beer, one glass of wine, one shot of liquor or one mixed drink)

FAMILY HISTORY

| | ALIVE | | DEAD | | | |
|------------|-------|---------------------------|------|---------------|--------------|-------|
| | Age | (check one) Well Ill | | Year of Death | Age at Death | Cause |
| Father | | | | | | |
| Mother | | | | | | |
| Brother(s) | | | | | | |
| Sister(s) | | | | | | |
| Spouse | | | | | | |
| Children | | | | | | |