Robert D. Marx, M.D.

Name: _____ Height: _____ Weight: _____ Date: _____

How many children do you have? ___ Born vaginally (from below) or C-section? (Circle one.) Number of abortions ___

Number of miscarriages ___ Do you take birth control pills? ___ Are you pregnant? ___ Planning pregnancy? ___

Telephone number (where you can be reached 9AM-7PM): _____

Circle ethnicity: Hispanic or Latino Not Hispanic or Latino

Circle race: American Indian of Alaska Native Black or African American Asian

Native Hawaiian or Other Pacific Islander White

Medical History:

__ Bladder problems
__ Blood in urine
__ Kidney disease/UTI
__ Kidney stones
__ Urethral discharge
__ Urine infections (frequent)
__ Prostate problems

__ Anesthetic complications
__ Arthritis/Rheumatism
__ ART Treatment
__ Autoimmune disorder
__ Back pain (recurrent)
__ Breast problems
__ Colon problems
__ -bloody or tarry stools
__ -change in bowel habits
__ -chronic abdominal pain
__ -diarrhea or constipation
__ Diabetes
__ D(Rh) Sensitized
__ Depression/Postpartum
__ Epilepsy/seizures
__ Frequent infections
__ Gall bladder trouble
__ Gout
__ Heart Disease
__ -heart trouble
__ -heart attack
__ -heart murmur
__ -chest pain
__ Hepatitis/Liver Disease
__ Hernia
__ History of abnormal PAP
__ History of blood transfusion
__ History of cancer
__ Radiation treatment
__ History of strokes (list number)
__ Hypertension
__ Illicit/Recreational Drugs
__ Indigestion or heartburn
__ Infertility
__ Loss of appetite
__ Neurologic/Epilepsy
__ Nervous condition
__ Osteoporosis
__ Pain/ bleeding during or after sex
__ Peptic ulcer
__ Persistent nausea/vomiting
__ Pneumonia
__ Psychiatric
__ Pulmonary condition
__ -asthma or breathing problems
__ -bronchitis/chronic cough
__ Rheumatic fever
__ Seasonal allergies
__ Swollen/menstrual dysfunction
__ Thyroid dysfunction
__ Thyroid or parathyroid disease
__ Tuberculosis
__ Tumor or growth
__ Ulcers
__ Uterine anomaly/DES
__ Varicosities/Phlebitis
__ Venereal disease
__ Weight loss
__ Weight gain
Other conditions worth noting:
_____

Family History:

	Father	Mother	Children	Siblings	Father's Parents	Mother's Parents
Epilepsy/ Convulsions	___	___	___	___	___	___
Bleeding	___	___	___	___	___	___
Cancer	___	___	___	___	___	___
Diabetes	___	___	___	___	___	___
Glaucoma	___	___	___	___	___	___
Asthma	___	___	___	___	___	___
Alcoholism	___	___	___	___	___	___
Heart Disease	___	___	___	___	___	___

	Father	Mother	Children	Siblings	Father's Parents	Mother's Parents
High blood pressure	___	___	___	___	___	___
Kidney Disease	___	___	___	___	___	___
Mental Illness	___	___	___	___	___	___
Migraine	___	___	___	___	___	___
Osteoporosis	___	___	___	___	___	___
Stroke	___	___	___	___	___	___
Thyroid Disease	___	___	___	___	___	___
Other:	_____					