Name _____Date of Birth _____Todays Date _____

Past Medical History ©2002

(Please provide details of your personal medical history, & indicate Dates & Treatment)

Asthma
Cancer
Diabetes
Hypothyroid or Thyroid Dysfunction
Epilepsy / Seizures
Tuberculosis and/or PPD +
Kidney Disease
Liver Disease / Hepatitis
Anxiety / Depression
Abuse
Mental Health Problem
Stomach Ulcers
Major Accidents
History of Blood Transfusion
Rh Sensitized / Rh Isoimmunization
Sexually Transmitted Disease
Herpes
Gonorrhea / Chlamydia
HIV / AIDS or Syphilis
Human Papilloma Virus / HPV
Abnormal Pap smear
Genital Warts
Endometriosis
Incontinence
Infertility / PCOS
Abnormal Uterus / Fibroids

Heart Disease / Stroke
Heart Murmur / Valve Prolapse
Deep Venous Thrombosis/ Pulmonary Emboli
Varicosities / Phlebitis
Hypertension

List all prior SURGERIES, major and minor:

List all hospital stays:

Tobacco use / Cigarettes:
Age started smoking:
Age stopped smoking:
Number of cigarettes/day

Alcohol Use:
Number of Drinks / Week

Do you use or have you used Recreational Drugs?
If yes, what drugs and when?
_____
_____
_____
_____

List ALL presently used MEDICATIONS along with their DOSAGE and FREQUENCY (including over the counter meds): _____
_____
_____

List ALL medications to which you are ALLERGIC: _____
_____

Past pregnancies

Year of Delivery	Length of Labor	Birth Weight	Type of Delivery	Male/Female & Name(s)	Place of Delivery	Comments / Complications

Please list all miscarriages (years occurred and # of weeks pregnant):_____
_____

Age at first period _____Date last menstrual period began _____ how many days? _____
Flow of periods are: normal _____heavier _____lighter _____ Are your periods regular? _____
How often? _____Do you have pain with periods? _____Does pain require medication? _____
If so what medications? _____ Date of last pap smear/result? _____
Present type of birth control used _____If oral contraception, name of pill_____

Family History

Breast Cancer_____ If yes, what relationship? _____Age @ diagnosis_____
Ovarian Cancer_____ If yes, what relationship? _____ Age @ diagnosis_____
Colon Cancer _____ If yes, what relationship? _____Age @ diagnosis_____
Other _____