



NAME _____ HOW DO YOU WISH TO BE ADDRESSED? _____ AGE _____
 DATE OF BIRTH _____ PLACE _____ REFERRED BY _____
 CURRENT OCCUPATION _____ PREVIOUS OCCUPATION _____
 RELIGION _____ HOME PHONE _____ WORK PHONE _____
 SINGLE MARRIED SEPARATED REMARRIED WIDOWED DIVORCED
 HIGHEST GRADE COMPLETED _____ DEGREE(S) AFTER HIGH SCHOOL _____
 FAMILY DOCTOR _____ HUSBAND'S NAME _____ HUSBAND'S OCCUPATION _____

MEDICAL HISTORY

PLACE AN AGE, IF KNOWN, IN APPROPRIATE COLUMN

SPECIFY YEARS OF BIRTH
MARK (X) FOR HEALTH

FOR ANY ILLNESS THAT YOU OR THE
RELATIVES LISTED HAVE NOW OR EVER HAD.

	YEAR OF BIRTH OR AGE	SPECIFY YEARS OF BIRTH FOR ANY ILLNESS THAT YOU OR THE RELATIVES LISTED HAVE NOW OR EVER HAD.																		FOR DECEASED RELATIVES LIST CAUSE AND AGE AT DEATH.								
		GENERALLY HEALTHY	AIDS	ALLERGIES OR ASTHMA	ANEMIA	BLEEDING TENDENCIES / BRUISING	BREAST CANCER	CLOTTING FACTORS	DEEP VEIN THROMBOSIS	DIABETES	EPILEPSY / SEIZURES	GLAUCOMA	GOUT	HEART TROUBLE	HEPATITIS	HIGH BLOOD PRESSURE	HPV	KIDNEY OR BLADDER ILLNESS	NERVOUS BREAKDOWN		OSTEOPOROSIS	PULMONARY ILLNESS	RHEUMATISM OR ARTHRITIS	STOMACH OR DUODENAL ULCER	STROKE	THYROID	TUBERCULOSIS	OTHER
YOURSELF																												
FATHER																												
MOTHER																												
BROTHERS																												
SISTERS																												
SPOUSE																												
CHILDREN																												
MATERNAL GRANDMOTHER																												
MATERNAL GRANDFATHER																												
PATERNAL GRANDMOTHER																												
PATERNAL GRANDFATHER																												

SPECIFY YOUR AGE AT ONSET FOR ANY OF THE FOLLOWING

- | | |
|--|---|
| <input type="checkbox"/> ECZEMA | <input type="checkbox"/> PHLEBITIS |
| <input type="checkbox"/> BRONCHITIS | <input type="checkbox"/> DIVERTICULITIS |
| <input type="checkbox"/> EMPHYSEMA | <input type="checkbox"/> COLITIS |
| <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> APPENDICITIS |
| <input type="checkbox"/> MEASLES | <input type="checkbox"/> HERNIA |
| <input type="checkbox"/> PNEUMONIA | <input type="checkbox"/> HEMORRHOIDS |
| <input type="checkbox"/> RHEUMATIC FEVER | <input type="checkbox"/> EYE DISEASE |
| <input type="checkbox"/> SCARLET FEVER | <input type="checkbox"/> GERMAN MEASLES (RUBELLA) |
| <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> CHICKEN POX |
| <input type="checkbox"/> MONONUCLEOSIS | <input type="checkbox"/> MUMPS |
| <input type="checkbox"/> PANCREATITIS | <input type="checkbox"/> MITRAL VALVE PROLAPSE |
| <input type="checkbox"/> GALL BLADDER | <input type="checkbox"/> BROKEN BONES |

CURRENT MEDICATIONS

ALLERGIES TO MEDICATIONS

EXERCISE: NONE REGULARLY OCCASIONALLY
 ALCOHOL: NONE DAILY WEEKLY SPECIAL OCCASIONS
 SMOKE: (packs per day) 0 1/2 1 1 1/2 2 MORE
 RECREATIONAL DRUGS: NO YES _____

NAME _____

SURGICAL HISTORY

LAST: TB TEST _____ CHEST X-RAY _____

DATE OF LAST TETANUS IMMUNIZATION _____ WAS IT MORE THAN 10 YEARS AGO? YES NO

TRANSFUSION _____ UNITS REACTION? YES NO

LIST OF MEMBERS OF FAMILY WHO DIED IN SURGERY OR WHO HAD ANESTHETIC COMPLICATIONS

YOUR SURGERY

AGE	YEAR	SURGERY	PHYSICIAN	HOSPITAL	COMPLICATIONS	OUTCOME

NON SURGICAL HOSPITALIZATION AND ILLNESSES

AGE	YEAR	CONDITION	PHYSICIAN	HOSPITAL	COMPLICATIONS	OUTCOME

HEIGHT _____ WEIGHT _____ IDENTIFYING FEATURES: HAIR _____ EYES _____ SCARS _____

DO YOU HAVE ANY MEDICAL CONDITIONS NOT ALREADY NOTED ON THESE FORMS? _____

ARE THERE ANY TOPICS YOU WOULD LIKE ADDRESSED? _____

MENSTRUAL HISTORY

AGE AT FIRST PERIOD _____ CYCLE EVERY _____ DAYS, FLOW OF _____ DAYS, PADS/TAMPONS PER DAY (HEAVY FLOW) _____

PAIN WITH PERIODS? YES NO AGE OF PAIN ONSET _____ RELIEF WITH _____

ABNORMAL BLEEDING? YES NO INFERTILITY PROBLEMS? YES NO

CONTRACEPTION: CURRENT METHOD _____

PAST METHODS: PILL DIAPHRAGM CONDOM IUD FOAM RHYTHM WITHDRAWAL DEPO PROVERA SPONGE OTHER _____

OBSTETRIC FAMILY HISTORY

	RELATIONSHIP	FAMILY BACKGROUND
STILLBORN OR NEONATAL DEATHS	_____	
BIRTH DEFECTS (DEAF, CLEFT PALATE, ETC.)	_____	<input type="checkbox"/> SCOT
DOWN'S SYNDROME	_____	<input type="checkbox"/> WELSH
MENTAL RETARDATION	_____	<input type="checkbox"/> ENGLISH
CONSANGUINITY (INTERMARRIED BLOOD RELATIVES)	_____	<input type="checkbox"/> IRISH
BLOOD DISEASES (HEMOPHILIA, SICKLE CELL, ANEMIAS)	_____	<input type="checkbox"/> MEDITERRANEAN
MUSCULAR DISEASES	_____	<input type="checkbox"/> GREEK
EPILEPSY	_____	<input type="checkbox"/> ITALIAN
CYSTIC FIBROSIS	_____	<input type="checkbox"/> GERMAN
TWINS	_____	<input type="checkbox"/> AFRICAN AMERICAN
		<input type="checkbox"/> ORIENTAL
		<input type="checkbox"/> JEWISH
		<input type="checkbox"/> ASHKENAZIC
		<input type="checkbox"/> SEPHARDIC

YOUR PREGNANCIES: _____ FULL TERM (37+ WEEKS) _____ 20-38 WEEKS _____ UNDER 20 WEEKS _____ CHILDREN LIVING

YOUR AGE AT DELIVERY	YEAR	PHYSICIAN	HOSPITAL	WEEKS GESTATION	HOURS LABOR	ANESTHESIA	SEX	BIRTH WEIGHT	VAGINAL / CESAREAN

DETAIL ANY KNOWLEDGE OF GENETIC HISTORY HOME _____ WORK _____

GYNECOLOGIC HISTORY

DID YOUR MOTHER RECEIVE ANY HORMONES/ DES WHILE PREGNANT WITH YOU? YES NO DON'T KNOW

YOUR AGE AT FIRST MARRIAGE _____

GONORRHEA SYPHLIS HERPES PID (PELVIC INFLAMMATORY DISEASE) VAGINAL WARTS HPV CHLAMYDIA IUD ASSOCIATED INFECTION

ABNORMAL PAP SMEARS: DATE: _____ COLPOSCOPY? YES NO CONE BIOPSY? YES NO

CERVICAL CAUTERY OR CRYOSURGERY: DATE: _____ LEEP: DATE: _____

D & C: DATE REASON

1. _____

2. _____

BREAST SELF EXAM? YES NO HOW OFTEN? EVERY _____ MONTH(S) DATE OF LAST MAMMOGRAM _____

NUMBER OF MONTHS NURSED: FIRST CHILD _____ SECOND CHILD _____ OTHER _____