FAMILY MEDICAL HISTORY

	IF LIVING Age	Health	IF DECEASED Age at Death	Cause	PLEASE CIRCLE Condition Present In Any Blood Relative:	Relation
FATHER					CANCER YES or NO	
MOTHER					TUBERCULOSIS YES or NO	
SIBLINGS 1.					DIABETES YES or NO	
2.					HEART TROUBLE YES or NO	
3.					STROKE YES or NO	
4.					EPILEPSY YES or NO	
5.					LIVER DISEASE YES or NO	
SPOUSE					KIDNEY DISEASE YES or NO	
CHILDREN 1.					ARTHRITIS YES or NO	
2.					ASTHMA YES or NO	
3.					BLOOD DISORDER YES or NO	
4.					OTHER CONDITION YES or NO	

Other Details: _____ _____ _____

PRESENT MEDICATIONS

Please indicate all prescription and non-prescription drugs that you currently take.

NAME OF DRUG	DOSAGE	HOW OFTEN PER DAY

WOMEN ONLY – MENSTRUAL HISTORY

Age at Onset_____

Cycles Regular? Yes ☐ No ☐

_____ Days (From Start to Start)

Flow Heavy ☐ Medium ☐ Light☐

Clots Passed? Yes ☐ No ☐

Pain or Cramps? Yes ☐ No ☐

DATE OF LAST PERIOD _____

DATE OF LAST PELVIC EXAM _____

DATE OF LAST PAP SMEAR _____

RESULTS: Positive ☐ Negative ☐

DATE OF LAST MAMMOGRAM

_____ Yes ☐ No ☐

Discharge or Itching From Vagina?

If Yes, What Color?_____

Do You Take Birth Control Pills? Yes ☐ No ☐

How Long Have You Taken Them?_____

Pregnancies

How Many Children Born Alive? _____

How Many Still Births? _____

How Many Premature Births? _____

How Many Caesarean Births? _____

How Many Miscarriages? _____

Any other complications with pregnancies _____

_____