Name: _____ Date: _____

Date of Birth: _____ Pharmacy: _____

Home telephone: _____ _____

What **medications** do you take (**include mg dose and how many times per day**)?

1._____ 6._____

2._____ 7._____

3._____ 8._____

4._____ 9._____

5._____ 10._____

What medical problems have you been **diagnosed** with?

1._____ 6._____

2._____ 7._____

3._____ 8._____

4._____ 9._____

5._____ 10._____

What **surgeries** have you had (**include procedure name and approximate year**)?

1._____ 4._____

2._____ 5._____

3._____ 6._____

What is your occupation? _____

Do you smoke?

Never [ ]

Yes [ ] How much? _____

Quit [ ] What year? _____

Do you drink alcohol?

Never [ ]

Yes [ ] How much? _____

Recovered [ ] What year?_____

Have you ever had an alcohol or substance abuse problem?

No [ ] Yes [ ] If yes, explain: _____

Please list any environmental allergies or reactions: None [ ]

_____

Who is your gynecologist? _____

COMPLETE OTHER SIDE

Name:_____ Date:_____

Please list **health problems** of only **immediate** family (parents, siblings, and children). Please include issues such as cancers, high blood pressure, heart attack, stroke, diabetes, thyroid or cholesterol problems, osteoporosis, etc.

	Alive	Deceased	Current Age or Age of Death	Health Problems
Father	[ ]	[ ]	_____	_____
Mother	[ ]	[ ]	_____	_____
_____	[ ]	[ ]	_____	_____
_____	[ ]	[ ]	_____	_____
_____	[ ]	[ ]	_____	_____
_____	[ ]	[ ]	_____	_____
_____	[ ]	[ ]	_____	_____
_____	[ ]	[ ]	_____	_____
_____	[ ]	[ ]	_____	_____
_____	[ ]	[ ]	_____	_____

Any family history of the following?
Prostate Cancer: Yes [ ] No [ ]
Colon Polyps or Cancer: Yes [ ] No [ ]
Breast or GYN cancer: Yes [ ] No [ ]

Do you have any of the following?

Unexplained weight loss [ ]
Recurrent fever [ ]
Change in vision [ ]
Contacts [ ] Glasses [ ]
Change in hearing [ ]
Hearing aid [ ]
Exertion chest pain [ ]
Palpitations [ ]
History of broken bone [ ]
Ankle swelling [ ]
Shortness of breath [ ]
Chronic cough [ ]
Heartburn [ ]
Blood in stool [ ]

Rashes [ ]
Easy bruising [ ]
Impotence [ ]
Incontinence [ ]
Abnormal menstruation [ ]
# of night time urination's [ ]
Lymph gland swelling [ ]
Anxiety [ ]
Depression [ ]
Dizziness [ ]
Sciatica [ ]
Rashes [ ]
Easy bruising [ ]
New or changing skin spots [ ]

None of the above [ ]
Explain any positive responses:

_____
_____
_____