MEDICAL HISTORY:

WEIGHT:_____ HEIGHT:_____ NAME_____D.O.B._____

ADMISSIONS TO HOSPITAL OR SURGERY: PLEASE LIST TYPE, DATE, AND COMPLICATIONS IF ANY.

1. _____

2. _____

3. _____

4. _____

MEDICATIONS: PLEASE LIST ANY MEDICATIONS YOU CURRENTLY TAKE; INCLUDING DOSAGE AND HOW OFTEN YOU TAKE IT.

1. _____

2. _____

3. _____

4. _____

DO YOU SMOKE? YES ( ) NO ( ) HAVE YOU EVER? YES ( ) NO ( ) HOW MANY PACKS A WEEK? _____

DO YOU CONSUME ALCHOLIC BEVERAGES? YES ( ) NO ( ) AMOUNT WEEKLY _____

DO YOU TAKE ASPIRIN? YES ( ) NO ( ) AMOUNT WEEKLY _____

DATE OF LAST TETNUS SHOT: _____ DATE OF LAST COLONOSCOPY_____ LAST FOBT_____

ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN FOR CHRONIC MEDICAL PROBLEMS?
EXPLAIN:

ALLERGIES:

ILLNESSES & MEDICAL PROBLEMS

DIZZY SPELLS	YES( ) NO( )	ARTHRITIS	YES( ) NO( )	HEPATITIS	YES( ) NO( )
EMPHYSEMA	YES( ) NO( )	SWELLING IN NECK	YES( ) NO( )	MONONUCLEOSIS	YES( ) NO( )
GLAUCOMA	YES( ) NO( )	BRUISE EASILY	YES( ) NO( )	GALL BLADDER TROUBLE	YES( ) NO( )
OTHER EYE TROUBLE	YES( ) NO( )	ANEMIA	YES( ) NO( )	STROKE	YES( ) NO( )
PNEUMONIA	YES( ) NO( )	ASTHMA	YES( ) NO( )	CONVULSION/SEIZURES	YES( ) NO( )
TUBERCULOSIS	YES( ) NO( )	BLEEDING DISORDER	YES( ) NO( )	SCARLET FEVER	YES( ) NO( )
EAR TROUBLE	YES( ) NO( )	BRONCHITIS	YES( ) NO( )	KIDNEY PROBLEMS	YES( ) NO( )
HIGH BLOOD PRESSURE	YES( ) NO( )	ANESTHESIA PROBLEMS	YES( ) NO( )	BLADDER PROBLEMS	YES( ) NO( )
DEAF/HEARING IMPAIRED	YES( ) NO( )	HEART ATTACK	YES( ) NO( )	VARICOSE VEIN	YES( ) NO( )
HEALING PROBLEMS	YES( ) NO( )	HEART MURMUR	YES( ) NO( )	DIABETES	YES( ) NO( )
HERNIAS	YES( ) NO( )	ANKLES SWELL	YES( ) NO( )	PARALYSIS	YES( ) NO( )
THYROID PROBLEMS	YES( ) NO( )	STOMACH ULCER	YES( ) NO( )	CANCER	YES( ) NO( )
NOSE BLEEDS	YES( ) NO( )	COLITIS	YES( ) NO( )	YEAR/TYPE OF CANCER:	_____
LOW BLOOD PRESSUE	YES( ) NO( )	DIVERTICULOSIS	YES( ) NO( )		
NOSE OBSTRUCTION	YES( ) NO( )	BOWEL PROBLEMS	YES( ) NO( )		

HAVE ANY OF THE ABOVE CONDITIONS APPEARED IN YOUR IMMEDIATE FAMILY?
IF SO, PLEASE SPECIFY.

WOMEN ONLY

DATE OF LAST PAP SMEAR	_____		
TENDER BREASTS	YES( ) NO( )	HOW MANY?	_____
LUMPS OR RECENT CHANGES IN SIZE OR COLOR	YES( ) NO( )	WERE YOUR CHILDREN BREAST FED?	YES( ) NO( )
FIBROCYSTIC DISEASE	YES( ) NO( )	IF YOU DO NOT HAVE CHILDREN, DO YOU PLAN TO HAVE CHILDREN?	YES( ) NO( )
YEAR OF LAST MAMMOGRAM	_____		
MENSTRUAL PROBLEMS	YES( ) NO( )	DO YOU HAVE A FAMILY HISTORY OF BREAST CANCER?	YES( ) NO ( )
LAST MENSTRUAL PERIOD	_____		
DO YOU HAVE CHILDREN?	YES( ) NO( )	IF SO, PLEASE LIST FAMILY MEMBERS.	