MEDICAL HISTORY INFORMATION

Name:				Date:	Medications:
Sex:	DOB:	Age:	Ht:	Wt:	
Known Drug Allergies:					
Date of last Physical:					
Surgeries:					
Date Last Pap:		Date Last Mammogram:			
Number of Pregnancies:		LMP:			

Do you or have you ever had chronic problems with:	YES	NO	Explanation:
Eyes			
Ears			
Headaches			
Nose			
Throat			
Chest			
Breathing			
Heart			
Chest			
Lungs			
Stomach			
Food Digestion			
Intestines			
Rectum			
Constipation			
Diarrhea			
Bladder			
Kidneys			
Urination			
Ovaries			
Uterus			
Cervix			
Menstruation			
Blood Disorders			
Immune Deficiency Disorder			
Testicles/Penis			
Sexually Transmitted Disease			
Skin			
Legs/Arms			
Depression			
Emotion Problems			
Sleep Problems			
Personal/Work Stress			

Please indicate family history: **M**other, **F**ather, **S**ister, **B**rother, **G**rand**m**other, **G**rand**f**ather

Cancer:		Heart Disease		HIV:	
Breast:		Heart Attack:		Ulcers:	
Prostate:		High Blood Pressure:		Gallbladder Disease:	
Other:		Diabetes:		Migraines:	
Stroke:		Blood Disease:		TB:	
Diabetes:		Mental Illness:		Thyroid:	
Seizures:		Asthma:			
Smoke?		# of Cigarettes:			
Drink Alcohol?		# of drinks/day		# drinks/wk	