PAST HISTORY

Current Medications _____

Allergies to Medicine _____ Type of Reaction _____

_____

Transfusions

Surgery

Type, date & place

(including cryosurgery on cervix) _____

_____

Hospitalizations

Reasons, date & place _____

_____

FAMILY HISTORY

	Living		Deceased	
	Age	Health Problems	Age	Cause
Mother 1				
Father 2				
Brother/Sister 3				
4				
5				
Husband 1				
Son/Daughter 2				
3				
4				

HAS ANY RELATIVE HAD:	YES	NO	WHO
1. Breast Cancer	☐	☐	_____
2. Other Cancer	☐	☐	_____
3. Tuberculosis	☐	☐	_____
4. Thyroid Disease	☐	☐	_____
5. Diabetes	☐	☐	_____
6. Heart Disease	☐	☐	_____
7. High Blood Pressure	☐	☐	_____
8. Stroke	☐	☐	_____
9. Epilepsy	☐	☐	_____
10. Suicide	☐	☐	_____
11. Mental Illness	☐	☐	_____
12. Kidney Disease	☐	☐	_____
13. Birth Defects	☐	☐	_____
14. Twins	☐	☐	_____
15. Bleeding Disorder	☐	☐	_____

SOCIAL HISTORY

Alcohol: Type _____ Quantity _____

Cigarettes _____ pack/day

Caffeine _____ cups/day

Drugs _____

Daily Exercises ☐ Yes ☐ No

Type _____

Occupation _____

Signature: _____

Date: _____