PATIENT'S NAME: _____ DATE: _____

Y N **ARE YOU ALLERGIC**
❑ ❑ to **MEDICINES**?
❑ ❑ to other things?

List Medicine Allergies Below:

Medicine Allergies

_____
_____
_____
_____
_____

Y N **HAD YOU ANY SERIOUS CHILDHOOD, i.e.**
❑ ❑ asthma
❑ ❑ rheumatic fever
❑ ❑ chicken pox, measles, mumps

Y N **HAVE YOU HAD ANY**:
❑ ❑ severe accidents
❑ ❑ fractures (broken bones)
❑ ❑ concussions

CURRENT MEDICATIONS:

_____
_____
_____
_____
_____

SURGERY OR BIOPSIES **You** HAVE HAD:

❑ Tonsillectomy
❑ Appendectomy
❑ Hernia-Rupture
❑ Gallbladder
❑ Breast Biopsy
❑ Tubal Ligation
❑ Hysterectomy
❑ C-Section
❑ D & C
❑ Vasectomy
❑ Hemorrhoidectomy
❑ Blood **Transfusion**
❑ Other Surgery:

_____
_____
_____

❑ Any other hospitalizations?

_____
_____
_____
_____

IMMUNIZATIONS:
Type Date
Tetanus _____
Other:

_____
_____
_____
_____

DISEASES **You** HAVE HAD:

❑ Anemia
❑ Cancer
❑ Leukemia
❑ Diabetes
❑ Thyroid Disease
❑ Glaucoma
❑ Lung Disease
❑ Tuberculosis
❑ Heart Attack, Angina
❑ Other Heart Disease
❑ High Blood Pressure
❑ Stroke
❑ Ulcers
❑ Colitis
❑ Liver Disease
❑ Gallbladder Trouble
❑ Kidney Stones/disease
❑ Gout
❑ Phlebitis
❑ Venereal Disease
❑ Seizure, Epilepsy
❑ Mental Illness
❑ Spine/back problems
❑ Other:

_____
_____
_____
_____
_____
_____

YOUR FAMILY (brothers, sisters, parents, grandparents, aunts, uncles) HAVE HAD

❑ Anemia
❑ Cancer
❑ Leukemia
❑ Diabetes
❑ Thyroid Disease
❑ Glaucoma
❑ Lung Disease
❑ Tuberculosis
❑ Heart Attack, Angina
❑ Other Heart Disease
❑ High Blood Pressure
❑ Stroke
❑ Ulcers
❑ Colitis
❑ Liver Disease
❑ Gallbladder Trouble
❑ Kidney Stones/disease
❑ Gout
❑ Phlebitis
❑ Venereal Disease
❑ Seizure, Epilepsy
❑ Mental Illness
❑ Other Serious Family Diseases:

_____
_____
_____
_____
_____

Y N **GYN HISTORY**: (Females Only)
❑ ❑ Using Birth Control
❑ ❑ Are your pregnant? Due Date_____
❑ ❑ Any problems with previous pregnancies?
❑ ❑ Have you had Rhogam?
❑ ❑ Do you have persistent spotting?
❑ ❑ Do you have frequent or prolonged periods?
❑ ❑ Have you passed through menopause?
❑ ❑ Have you had any abnormal pap smears?
____ Your age when you had first period
____ If pregnant, your due date
____ Number of pregnancies
____ Number of live births
____ Number of miscarriages
____ Number of abortions
____ Date of last menstrual period
____ Number of days between periods
____ Number of days periods last
____ Number of workdays per month lost to periods

❑ Married ❑ Single ❑ Divorced ❑ Separated

Occupation _____

Y N
❑ ❑ Do you feel depressed?
❑ ❑ Do you have trouble eating or sleeping?
❑ ❑ Do you feel nervous much of the time?
❑ ❑ Do you smoke?
Number of packs per day _____
Number of years smoked _____
Have not smoked since: _____
❑ ❑ Do you drink alcohol?
Number of alcoholic drinks per week _____
Type of alcoholic drinks _____
❑ ❑ Do you drink coffee?
Number of cups of coffee per day _____