

PAST MEDICAL HISTORY

Date: _____

Name: _____
Last First M.I.

1. Please list any allergies to medications: _____

2. Please list any medications you take: _____

3. Do you smoke? _____ How much? _____

4. Hospitalizations & approximate dates: _____

5. Surgery (inpatient & outpatient) & approx. dates: _____

6. Have you ever had:

An abnormal pap smear _____	Heart trouble _____	Cancer _____
Herpes _____	Heart murmur _____	Jaundice (Hepatitis) _____
Genital warts _____	High blood pressure _____	Ulcer symptoms _____
Menopausal symptoms _____	Diabetes _____	Rectal bleeding _____
Bladder trouble _____	Thyroid trouble _____	Hemorrhoids _____
Kidney trouble _____	Epilepsy _____	
Asthma _____	Anemia _____	

7. Has any blood relative had any of the following diseases?

Heart disease _____	Cancer of breast, ovary, or other _____ (list type)
Cystic fibrosis _____	Tuberculosis _____ High blood pressure _____
Diabetes _____	Other _____

8. Husband's age _____
If not living, give cause of death & age at that time

Mother's age _____
If not living, give cause of death & age at that time

Father's age _____
If not living, give cause of death & age at that time

9. Menstrual History:

Onset and age _____ Interval _____ days Duration _____ days
Last normal period _____ (date) Irregularities _____
Cramps _____ (mild) _____ (moderate) _____ (severe) _____
Medications for cramps, if any _____

10. Obstetrical History:

Total pregnancies _____ Full term _____ Premature _____ Miscarriages _____
First Pregnancy (month/year) _____ Last Pregnancy (month/year) _____
Complications of pregnancy: High blood pressure _____ Kidney infection _____
Hemorrhage _____ Excessive weight gain _____
Caesarean _____ Babies over 9 pounds _____
Toxemia _____ Anemia _____

11. Contraception, if any (method of birth control) _____

12. Normal average weight _____

13. Date of last pap or cancer smear _____

14. Other pertinent medical issues or concerns

