

SURGERIES*(list type, year, anesthesia, complications)*

FEMALES ONLY / GYNECOLOGIC HISTORY

Pregnancies _____ Births _____ Miscarriages _____

1st Day of Last Menstrual Period: _____ Method of Birth Control: _____

Age at Onset of Periods: _____ Frequency: _____ Length of Period: _____

_____ Leakage of Urine _____ Abnormal Discharge _____

_____ Prolonged or Abnormal Bleeding _____ Abnormal Pap Smear, type or treatment _____

_____ Pelvic Pain _____ Gynecologic Surgeries and reason why _____

LAST PAP _____ LAST MAMMOGRAM _____ LAST BREAST EXAM _____

IMMUNIZATION / HEALTH CARE MAINTENANCE LIST*(list dates and abnormal findings)*

_____ Hepatitis B _____ Flexible Sigmoidoscopy _____

_____ Pneumovax _____ Stool Check for Blood _____

_____ Flu Shot _____ Cholesterol Check _____

_____ Tetanus Booster _____ Prostate Check / PSA Level _____

_____ TB Skin Test _____ Last EKG (electrocardiogram) _____

_____ Eye Exam, intraocular pressure check _____ Last Chest Xray _____

FAMILY HISTORY*(parents, grandparents, siblings)**Family Member Age at Onset:*

_____ Cancer _____

_____ High Blood Pressure _____

_____ Heart Disease _____

_____ Diabetes _____

_____ Strokes _____

_____ Drug or Alcohol Addiction _____

_____ Glaucoma _____

_____ Bleeding Diseases _____

_____ Other: _____

MEDICATIONS*(dosage, frequency)*

PERSONAL HABITS / RISK FACTORSDo you have a Living Will? No YesSmoking No Yes # Packs per Day _____ # Years _____ Quit: _____Alcohol No Yes Type _____ Amount per Week _____Drugs (marijuana, cocaine, crack, etc.) No Yes _____Have you engaged in activity putting you at risk of getting AIDS? No YesHave you ever worked with hazardous materials, asbestos, chemicals? No YesHistory of Blood Transfusions? No Yes Year _____Do you wish to be tested for AIDS? No YesAre you in a relationship in which you have been physically hurt by your partner? No YesAre you experiencing any sexual dysfunction/dissatisfaction? No Yes