

General Medical History—please indicate if you have a history of the following:

- | | | |
|--|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Eating disorders | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Angina/chest pain | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Phlebitis/blood clots |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Headaches | <input type="checkbox"/> Seizures/convulsions |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Skin disorders |
| <input type="checkbox"/> Bladder infections | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Stroke/mini-stroke |
| <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Heart failure | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Blood transfusions | <input type="checkbox"/> Heart murmur | |
| <input type="checkbox"/> Cancer (type: _____) | <input type="checkbox"/> Hepatitis/liver disease | |
| <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Other (_____) |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High cholesterol | |
| <input type="checkbox"/> Drug/alcohol dependency | <input type="checkbox"/> Irregular heartbeat | |

Family History—please indicate if any family members (parents, grandparents, siblings, children) have the following:

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Ovarian Cancer | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Other Cancer |

Surgical History/Hospitalizations—please list all surgical procedures and hospitalizations (excluding childbirth):

Year	Reason for Hosp/Surgical Procedure	Complications, if any
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication allergies—please list both the medication and the reaction below:

- | | |
|-----------------|---------------|
| Medication_____ | Reaction_____ |
| Medication_____ | Reaction_____ |

Current Medications (including over the counter medications, herbs and vitamins):

Medication	Strength	How often?	What is it for?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Personal Habits

Do you smoke cigarettes? Yes No How many per day? _____

Do you drink alcohol? Yes No How much per day/week? _____

Do you use recreational drugs? Yes No What drug do you use? _____
How often? _____

Do you exercise regularly? Yes No Activity? _____
How often? _____

If there are any concerns regarding your visit, or aspects of your health history that were not covered above, please explain below: _____
