Patient Name:_____ Date of Birth:_____

FAMILY MEDICAL HISTORY

Please circle "Y" or "N" if a member of your family has had the following and identify the family member.

Y N Heart attack:_____

Y N Heart failure: _____

Y N High blood pressure:_____

Y N Stroke:_____

Y N Abnormal bleeding tendencies:_____

Y N Kidney disease:_____

Y N Diabetes:_____

Y N Colon cancer:_____

Y N Colon problems:_____

Y N Breast cancer:_____

Y N Hepatitis:_____

Y N Epilepsy or seizures:_____

Y N Abnormal reaction to anesthesia:_____

FEMALE HISTORY

Y N Are you pregnant now?

Date of 1st day of last mentrual cycle:_____

Number of pregnancies:_____

Number of miscarriages:_____

Number of abortions:_____

Number of C-section deliveries:_____

Number of living children:_____

ALLERGIES

Please list any drug or food allergies that you have.

_____

_____

_____

_____

_____

_____

CURRENT MEDICATIONS

Please list all medications that you currently take.

_____

_____

_____

_____

_____

_____

_____

SURGERIES & HOSPITALIZATIONS

Please list all previous surgeries, hospitalizations, and dates below.

_____

_____

_____

_____

_____