Past Medical History:

Mark an **X** in the box next to any of the following that you have now or ever had. To the right of the disease write the approximate time(s) of occurrence, using your age(s), date(s), or approximate time period such as, "in high school". Since many of these "diseases" are really broad categories, please write to the right of the disease any other comments that might be helpful to us such as the type, cause or exact diagnosis if known.

- ☐ Anemia
- ☐ Blood Clot Problems
- ☐ Cancer
- ☐ Diabetes
- ☐ Alcoholism
- ☐ Osteoporosis
- ☐ Drug Addiction
- ☐ Epilepsy
- ☐ Neurologic Disease
- ☐ Glaucoma
- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ Heart Trouble
- ☐ High Cholesterol
- ☐ Thyroid Problems
- ☐ Asthma
- ☐ Pneumonia
- ☐ Stomach or Duodenal Ulcer
- ☐ Eating Disorder
- ☐ Pancreatitis
- ☐ Lyme Disease
- ☐ Liver Disease
- ☐ Kidney Stones
- ☐ Kidney Failure
- ☐ Kidney Infection
- ☐ Bladder Infection
- ☐ Uterine Fibroid
- ☐ Ovarian Cyst
- ☐ Physical Handicap _____
- ☐ Congenital Disease
- ☐ Hernia (location) _____
- ☐ Other _____
- ☐ Other _____

Note: Surgeries, Infections, and Reproductive problems are covered in other sections

Infectious Diseases

Mark an X in the box and note approximate date of infection if beyond normal childhood timing.

☐ Mononucleosis	☐ Polio
☐ Chicken Pox	☐ Measles
☐ German Measles	☐ Mumps
☐ Scarlet Fever	☐ Malaria
☐ Tuberculosis	☐ Hepatitis A
☐ Rheumatic Fever	☐ Hepatitis B
☐ Other _____	☐ Hepatitis C

If you think you night have AIDS, or desire an AIDS test simply discuss it with us confidentially.

Hospitalizations: Describe reasons and dates for past hospitalizations and surgeries; list fractures and other major injuries. Do not include normal vaginal deliveries. _____

_____

_____

☐ If you need more room mark an X in the box and use back.

Allergies to Medications:

_____

_____

Other Allergies: (i.e. foods, dust, cats)

_____

_____

_____

Menses (woman only):

Please try to describe the frequency of your menstrual cycle.
Example "every 28 to 32 days"
Approx. date of Menopause: _____
Or if still menstruating, please describe your menstrual flow: Number of heavy days_____
Light days_____ Total days _____
Do you feel it is excessively heavy_____
Unusually light_____
How would you rate your menstrual cramps?
None Moderate Severe Variable (circle range)