NAME ______________________________

PAST MEDICAL HISTORY:

	NO	YES	FAMILY YES		NO	YES	FAMILY YES
MEASLES				KIDNEY DISEASE			
MUMPS				LIVER DISEASE			
CHICKEN POX				HIGH BLOOD PRESSURE			
RHEUMATIC FEVER				TUBERCULOSIS			
SCARLET FEVER				ANEMIA			
VENEREAL DISEASE				ASTHMA			
SEIZURES-EPILEPSY				DIABETES			
THYROID TROUBLE				STROKE			
EMPHYSEMA				HEART DISEASE			
HEPATITIS				COLON(BOWEL) DISEASE			
OTHER							

PAST SURGERY (LIST ALL – TONSILS, APPENDIX, HYSTERECTOMY, GALLBLADDER, ETC.)

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____

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____

LIST ALL MEDICATIONS YOU ARE PRESENTLY TAKING. (PRESCRIPTION OR NOT) AND HOW OFTEN YOU TAKE THEM (INCLUDE LAXATIVE, ASPIRIN, ANTACIDS, BIRTH CONTROL PILLS, ETC.) ______________________________

____

HABITS:	NO	YES	IF YES, HOW MUCH DAILY?
SMOKING			
ALCOHOL			
DRINK COFFEE			
DRINK TEA			

LIST ALL ALLERGIES TO DRUGS, FOODS, ETC.

____

____

FEMALES ONLY: Age when first period began _______. Age when you stopped having periods ______. Last Menstrual period (date) _________. Duration of period (days) ________. Do you have problems with your period? ____________. Number of children _________. Number of Miscarriages ___________ Number of Abortions _______. Do you have any breast problems? (pain, Lumps, discoloration, etc) __________.

DATE ________________ SIGNATURE ______________________________

NEAREST RELATIVE ____________________ ADDRESS ______________________________

PHONE NUMBER ______________________________

MA-018 (5/07)