

NAME: _____ DATE: _____

AGE: _____ OCCUPATION: _____

MARITAL STATUS: S M D W

HABITS:

SMOKING HISTORY: YES, how much? _____ NOT EVER
NOT NOW, how much, how long? _____

ALCOHOL: YES, how much/how often? _____ NONE _____

CAFFEINE: YES, how much? _____

STREET _____

DRUGS _____

MEDICAL HISTORY:

ALLERGIES: _____

MEDICATIONS: _____

SURGERIES: _____

FAMILY HISTORY:

CANCER: _____

BREAST

CANCER: _____

ILLNESSES: _____

YOUR PERSONAL HISTORY:

SEXUALLY ACTIVE: YES _____ NOT NOW _____ NOT EVER _____

CONTRACEPTION: YES, what kind? _____

TUBAL: YES _____ NO _____

VASECTOMY: YES _____ NO _____

DATE OF LAST MAMMOGRAM: _____

BREAST

BIOPSY: _____

DATE OF LAST

COLONOSCOPY: _____

MEDICAL

PROBLEMS: _____

ANY PROBLEMS WITH ANY OF THE FOLLOWING?

- | | |
|-------------------------|----------------|
| Head | Muscles |
| Eyes | Skin |
| Ears | Nervous System |
| Nose | Mental |
| Throat | Diabetes |
| Lungs | Thyroid |
| Gastrointestinal system | Coagulation |
| Urinary | |

GYNECOLOGY HISTORY:

G _____ P _____ AB _____ MISCARRIAGES _____ C-SECTIONS _____

HOW MANY LIVING CHILDREN DO YOU HAVE? _____

DATE OF LAST PERIOD: _____

HOW LONG DOES YOUR BLEEDING LAST? _____
