

MEDICAL HISTORY

NAME _____

DATE OF BIRTH _____ HEIGHT _____ WEIGHT _____

ALLERGIES _____ SMOKING _____

FAMILY HISTORY: (please list family member)

DIABETES _____

CANCER (type/family member) _____

HEART DISEASE _____

ELEVATED CHOLESTEROL _____

GENETIC DISORDERS _____

OSTEOPOROSIS _____

THYROID DISORDER _____

OTHER _____

PERSONAL HISTORY

MEDICAL HISTORY _____

HOSPITALIZATIONS _____

SURGICAL HISTORY _____

ABNORMAL PAP SMEARS _____

LAST PAP SMEAR _____

LAST MAMMOGRAM _____

LAST BONE DENSITY _____

LAST COLONOSCOPY _____

LAST CHOLESTEROL SCREENING _____

MEDICATION LIST _____

TYPE OF DELIVERY _____ DATE _____

PREGNANCIES _____

SIGNATURE _____ DATE _____