

Name \_\_\_\_\_

Date \_\_\_\_\_

**HAD YOU EVER HAD PROBLEMS OR SURGERIES (PLEASE CIRCLE YES OR NO)**

High Blood Pressure	Yes	No	Low Blood Pressure	Yes	No		
Heart Murrur	Yes	No	Abnormal Heart Rhythm	Yes	No		
Blood Clots	Yes	No	Phlebitis	Yes	No		
Heart Attack	Yes	No	Diabetes	Yes	No		
Thyroid Disorder	Yes	No	Asthma	Yes	No		
Brochitis	Yes	No	Pneumonia	Yes	No		
Ulcers	Yes	No	Hepatitis	Yes	No		
Pancreatitis	Yes	No	Colitis	Yes	No		
Gallbladder Disease	Yes	No	Kidney Stones	Yes	No		
Kidney Infections	Yes	No	Bladder Infection	Yes	No		
Tuberculosis	Yes	No	Cancer	Yes	No		
Seizures	Yes	No	Migraine Headaches	Yes	No		
Concussion	Yes	No	Meninfitis	Yes	No		
Anemia	Yes	No	Herpes	Yes	No		
Tonsillectomy	Yes	No	Appendectomy	Yes	No		
Hernia	Yes	No	Ovarian Cyst	Yes	No	L	R
Hysterectomy	Yes	No	Cesarean Section	Yes	No		

Please List any other surgeries \_\_\_\_\_

Have you had a Blood Transfusion	Yes	No	Are you at risk for AIDS	Yes	No
LIST ALL ALLERGIES			LIST ALL CURRENT MEDICATIONS		

\_\_\_\_\_  
\_\_\_\_\_

**HABITS**

Do you currently smoke? Yes No  
 Do you drink alcohol? Yes No  
 Number of drinks per week? \_\_\_\_\_

List any restrictions \_\_\_\_\_  
Please decribe exercise program \_\_\_\_\_

**HAS ANY BLOOD RELATIVE EVER HAD OR BEEN TREATED FOR**

	Yes	No	Relationship	Age
High Blood Pressure	Yes	No	_____	_____
Diabetes	Yes	No	_____	_____
Stroke	Yes	No	_____	_____
Heart Attack	Yes	No	_____	_____
Congenital Defects	Yes	No	_____	_____
Breast Cancer	Yes	No	_____	_____
Other Cancer	Yes	No	1 _____ Type	_____
			2 _____ Type	_____

**Women only O.B History**

Number of Pregnancies \_\_\_\_\_  
 Miscarriages or AB's \_\_\_\_\_  
 Total live births \_\_\_\_\_  
 Birth control method \_\_\_\_\_  
 Age at 1st Delivery \_\_\_\_\_  
 Did you breast feed? Yes No

**Menstrual History**  
 Age at onset \_\_\_\_\_  
 Regular Yes No  
 Days in cycle (start to start) \_\_\_\_\_  
 Flow? Heavy Medium Light  
 How many days do you bleed? \_\_\_\_\_