HISTORY

STRICTLY CONFIDENTIAL

PRINT NAME ______________________ SSN: ____________ AGE ______ BIRTHDATE ________

ADDRESS ____
STREET CITY COUNTY STATE ZIP

TELEPHONE ( ) ____________ ( ) ____________ INSIDE CITY LIMITS? ____ ____ RACE ________
HOME BUSINESS YES NO

CITY/STATE OF BIRTH ______________________ MARITAL STATUS ____________ RELIGION ________

*EDUCATION (circle highest completed) 8 9 10 11 12 Undergrad 1 2 3 4 Post Grad ____ OCCUPATION ____________

IN CASE OF EMERGENCY NOTIFY: * for statistical purposes only

NAME ______________________ RELATIONSHIP ____________ PHONE ________

ADDRESS ______________________ CITY ____________ STATE ______ ZIP ________

MEDICAL HISTORY

Are you currently breast feeding? ____________

Are you taking any medicine regularly?
(Including contraceptive devices)

______ yes ______ no

List: ____________________

ANY FOOD, DRUG ALLERGIES OR SENSITIVITIES?

______ yes ______ no

List: ____________________

Have you ever had:	yes	no
Emotional or Mental Illness		
Anemia		
Sickle Cell Disease		
Asthma		
Heart Disease		
Heart Murmur		
Diabetes		
Epilepsy/Seizures		
Rheumatic Fever		
Serious Liver Disease		
Kidney Disease		
Hepatitis		
HIV		
Tuberculosis		
High Blood Pressure		
Low Blood Pressure		
Cancer		
Thyroid Problems		
Bronchitis, Chronic Cough		
Gonorrhea		
Syphilis		
Sexually Transmitted Diseases (STD)		
Pelvic Inflammatory Disease		
Pelvic Infection (Uterus, Tubes, Ovaries)		
Any Female Problems		
Blood Transfusions		
Lung Problems		
Bleeding or Clotting Problems		
Malignant Hyperthermia		
Previous Surgery: Operations		

When: ____________________

What Type: ____________________

	yes	no
General Anesthesia:		
Complications, If any		

Other Illnesses not Mentioned above: ____________________

____

PREGNANCY HISTORY

Last Normal Period ____________________

Number of previous pregnancies ____________________

Cesarean Section ____________________

Number of premature deliveries ____________________

Number of live births ____________ Now living ____________

Date of last live birth ____________________

PREVIOUS ABORTIONS					
MISCARRIAGE			INDUCED		
No.	Date of Last Miscarriage	Pregnancy in No. of Weeks	No.	Date of Last Abortion	Pregnancy in No. of Weeks

Ectopic/Tubal Pregnancy ______ yes ______ no ______ year

Any problems or surgery of the cervix or uterus? ____________________

____

Date of last PAP smear ____________________

FAMILY HISTORY AND YEAR (MOTHER, FATHER, SIBLING)

Cancer ____________ Diabetes ____________

TB ____________ Heart Disease ____________

History of twins ____________ Kidney Disease ____________

Malignant Hyperthermia ____________________

Other ____________________

Please ✓ answers to the following questions:	yes	no
Have you had a cold or flu in the past six weeks?		
Do you have dentures or loose teeth?		
Do you smoke? (____ packs per day)		
Do you drink alcoholic beverages? (___ occasionally ____ daily)		
Do you use or have used recreational drugs?		

What: ____________________

When: ____________________

Future BC method: ____________________

Do you currently have an IUD in place? ____________________

I verify that the above information is true to the best of my ability.

Patient
Signature ____________________ Date ____________