PERSONAL HISTORY FORM

Name_____ Date_____

Please list the following:

Operations Approximate Date

_____

_____

_____

Pregnancies_____Deliveries_____Miscarriages_____Abortions_____

Hospitalizations (List Reason)

_____

_____

_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING? IF SO, FOR HOW LONG?

Hypertension_____

Diabetes_____

Cancer (type)_____

Heart Disease_____

Emphysema or Asthma_____

Strokes_____

Rheumatic Fever_____

Kidney Disease_____

Tuberculosis_____

Ulcers or Colitis_____

Migraine Headaches_____

Other_____

DO YOU HAVE ANY RELATIVES WITH THESE ILLNESSES? WHO? (relationship)

Hypertension_____

Diabetes_____

Cancer (type)_____

Heart Disease_____

Tuberculosis_____

Emphysema_____

Strokes_____

Kidney Disease_____

Other_____

PLEASE LIST THE HEALTH CONDITION AND AGE OF YOUR PARENTS AND SIBLINGS

Mother_____

Father_____

Brothers_____

Sisters_____

Do you smoke? Yes/No If yes, how much?_____Do you chew tobacco? Yes/No
Do you drink alcohol? Yes/No If yes, how much per week?_____
How much coffee do you drink a day?_____cups, Caffeinated? Yes/No
How much tea do you drink a day?_____glasses, Caffeinated? Yes/No
How many caffeinated soft drinks a day?_____
How many hours of sleep do you get a night?_____hours
Have you been feeling depressed lately? Yes/No

What kind of work do you do?_____

Are you (please circle) Single Married Divorced Widowed

How old are your children? (if any) _____

Other comments, problems, systems:

For Women:

Please list your number of:
Pregnancies_____Deliveries_____Miscarriages_____Abortions_____Stillborns_____
Do you menstruate? Yes/No If yes, how long is your cycle? _____days.
How many days do you bleed?_____days. Do you have cramping? Yes/No
Do you have vaginal discharge? Yes/No If yes, please describe_____
Do you have any pain during intercourse? Yes/No_____
Do you have any sexual problems? Yes/No_____
Have you ever had a pelvic infection? Yes/No_____
Have you ever had a venereal disease? Yes/No_____
Do you have any hot flashes? Yes/No _____
Do you have any lumps in your breasts? Yes/No_____
Do you have any breast pain or tenderness beyond mild premenstrual tenderness? Yes/No
Have you had discharge from either nipple? Yes/No_____
Do you have any relatives with breast cancer (alive or deceased)? Yes/No
Who?_____
Do you leak urine when you cough, sneeze, or laugh? Yes/No_____