NAME:_____ BIRTH DATE:_____ DATE:_____

TAHOE FOREST WOMEN'S CENTER

## Past Medical History

| | Checkmark if you have a personal or family history of the following | SELF | FAMILY |
|---|---|---|---|
| 1 | Allergies/Drug Sensitivities | | |
| 2 | Skin/Hair Problems | | |
| 3 | High Blood Pressure | | |
| 4 | Thyroid Disease | | |
| 5 | Diabetes | | |
| 6 | Anemia/Bleeding Disorder/Sickle Cell | | |
| **7** | Breast Disease | | |
| 8 | Lung Disease (Asthma, TB, Emphysema) | | |
| 9 | Heart Disease, Heart Attack Under Age 50 | | |
| 10 | Rheumatic Fever | | |
| 11 | Mitral Valve Prolapse | | |
| 12 | Clots, Phlebitis, Embolism, Stroke | | |
| 13 | Varicose Veins | | |
| 14 | Migraine Headaches | | |
| 15 | Fainting, Dizziness | | |
| 16 | Liver Disease, Hepatitis, Jaundice | | |
| 17 | Gallbladder Disease | | |
| 18 | Ulcer, Other Intestinal Disease | | |
| 19 | Hernia | | |
| 20 | Kidney Problems | | |
| 21 | Bladder/Urinary Tract Infection | | |
| 22 | Vaginitis | | |
| 23 | PID (Pelvic Inflammatory Disease) | | |
| 24 | Abnormal PAP Smear | | |
| 25 | Sexually Transmitted Disease (Circle One) | | |
| | Gonorrhea, Syphilis, Herpes, Chlamydia, Warts | | |
| 26 | Infertility | | |
| 27 | DES Exposure | | |
| 28 | AIDS/ARC | | |
| 29 | Premenstrual Syndrome | | |
| 30 | Other Gynecologic Problems | | |
| 31 | Muscle/Bone/Joint Disease | | |
| 32 | Seizures, Epilepsy, Neurologic Disease | | |
| 33 | Depression, Psychiatric Illness | | |
| 34 | Cancer | | |
| 35 | Major Accident | | |
| 36 | Blood Transfusions | | |
| 37 | Surgeries/Operations (List With Dates) | | |
| | | | |
| | | | |
| 38 | Anesthetic Complications/Reactions | | |
| 39 | Tobacco Use (Circle One): Ever or Currently How Many Years?_____ | | |
| 40 | Alcohol Use Currently: # of Drinks Per Week _____ | | |
| 41 | Street Drugs: Types_____ | | |
| 42 | List Any Current Medications You Are Taking And Dosage: | | |
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