



PAST MEDICAL HISTORY

Chart # \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

PAST MEDICAL HISTORY (Circle if positive)

- |                          |                     |                              |
|--------------------------|---------------------|------------------------------|
| Headaches                | Liver Disease       | Benign Tumors                |
| Seizures                 | Chlamydia           | Mitral Valve Prolapse        |
| Thyroid Disease          | Syphilis            | Kidney Disease               |
| Pneumonia                | Herpes              | Eating Disorder              |
| Asthma                   | Vaginal Warts       | Breast Cancer                |
| Heart Disease            | Abnormal Pap Smears | Bladder Infections           |
| Blood Transfusion        | Hemorrhoids         | Blood Clots in legs or lungs |
| Anemia                   | Infertility         | Tuberculosis                 |
| Gallstones               | Endometriosis       | Diabetes                     |
| Bowel Problems           | Hypertension        | GERD/Reflux                  |
| Blood Clotting Disorders | Mental Illness      |                              |
| Gonorrhea                | Cancer              |                              |

Please list all hospitalizations and surgeries including deliveries and c-sections:

DATE	SURGERY	REASON

FAMILY MEDICAL HISTORY

Please list ages of parents and children.

RELATION	AGE (if deceased, at what age, and cause of death)
Father	
Mother	
Spouse	
Your Children	

Have any of your first degree relatives (father, mother, brother, sister, daughter, son) ever had any of the following? (Leave blank if NO)

DISEASE	RELATIVE
<b>Cancer:</b>	
Breast	
Ovarian	
Colon	
Melanoma	
Other	
Heart Disease	
High Blood Pressure	
Diabetes	
Endometriosis	
Infertility	
Birth Defects	
Mental Illness	
Melanoma	
Thyroid Disease	
Osteoporosis	
Other	

Signature: \_\_\_\_\_ Date: \_\_\_\_\_