FAMILY MEDICAL HISTORY

	AGE	PROBLEMS	DECEASED?
Father	______	______________________	_____
Mother	______	______________________	_____
Brothers	______	______________________	_____
	______	______________________	_____
Sisters	______	______________________	_____
	______	______________________	_____
Children	______	______________________	_____
	______	______________________	_____
Aunts/Uncles	______	______________________	_____
	______	______________________	_____

THIS AREA FOR WOMEN ONLY

How many pregnancies __________

How many deliveries ____________

Last menstrual period __________

Last Pap smear ___________

Have you taken estrogen, oral contraceptives or hormones in the last 10 years? ________

PLEASE MARK ALL THAT APPLY AS OF TODAY'S VISIT

___Fever
___Chills
___Weight loss
___Weight gain
___Blurred vision
___Double vision
___Cataracts
___Ear infection
___Nasal drainage
___Sore throat
___Chest pain
___Heart attack
___Palpitations
___Sleep with head elevated
___Leg edema

___Shortness of breath
___Cough
Productive yes / no
___Blood in sputum
___Nausea/Vomiting
___Blood in stool
___Diarrhea
___Constipation
___Heartburn
___Stomach Ulcers
___Pain with urination
___Increased frequency
___Blood in urine
___Kidney stones
___Rash
___Lumps/masses/knots

___Implants
___Seizures
___Stroke
___Dizziness
___Weakness
___Depression
___Anxiety disorder
___Hypothyroid
___Hyperthyroid
___Adrenal mass
___Anemia
___Bleeding disorder
___Clotting disorder
___Arthritis
___Limited movement

PATIENT SIGNATURE: ______________________________

PHYSICIAN SIGNATURE: ____________________________

DATE: ______________