

Name _____ Date _____

Current Medical Problems (Please circle any that are new in the past year):

- High blood pressure
- Seizure disorder
- Blood clots in leg/lung
- Thyroid disease
- Hepatitis
- Smoker ___cigarettes/day
- Other _____
- Diabetes
- Migraines
- Kidney disease
- Cancer _____
- Asthma or other respiratory problems
- Alcohol ___drinks/day
- Heart disease
- Mood disorder

Please list any surgery that you have had during the past year.

Please list all of your medications. Circle any that are new in the past year.

Please list your current allergies. Circle any that are new in the past year.

In the past year, has your mother, father, sisters, brothers been diagnosed with:

- Breast Cancer
- Heart attack before age 50
- Ovarian Cancer
- Diabetes
- Colon Cancer

Have you had an abnormal Pap smear since we've last seen you? Yes No

When was your last mammogram? _____ Was it normal? _____

When did you last have a cholesterol screening? _____ Was it normal? _____

When did you last have your thyroid tested? _____ Was it normal? _____

Have you ever had a bone density test? Yes No When, if yes? _____

Have you ever had a colonoscopy? Yes No When, if yes? _____