PERSONAL MEDICAL HISTORY

Patient Name: _____ DOB: _____

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Alcoholism/Drug Abuse			
Asthma			
Cancer (type:_____)			
Depression/Anxiety/Bipolar/Suicidal			
Diabetes (type:_____)			
Emphysema (COPD)			
Heart Disease			
High Blood Pressure (hypertension)			
High Cholesterol			
Hypothyroidism/Thyroid Disease			
Renal (kidney) Disease			
Migraine Headaches			
Stroke			
Other:			
Other:			

SURGERIES

TYPE *(specify left/right)*	DATE	LOCATION/FACILITY

WOMEN'S HEALTH HISTORY

Date of Last Menstrual Cycle:	Age of First Menstruation: _____ Age of Menopause: _____
Total Number of Pregnancies:	Number of Live Births:
Pregnancy Complications:	