Medical History

Medical ___ None (High blood pressure, Diabetes, Cancer, Heart Disease, etc.)

Pregnancy History

Year Sex Complications

Surgical ___ None (Tonsillectomy, Appendectomy, Hysterectomy, Hernia, etc.)

GYN Breast Colon History

Last Pap: ___________
Last Mammo: ___________
Colonoscopy: ___________
Sigmoidoscopy: ___________
Regular periods: ___________
Length of periods: ___________
Age at 1st period: ___________

Allergies to medications ___ None (If yes, please explain type of reaction, i.e. hives, wheezing, upset stomach, swelling, etc.).

Current prescription medicines ___ None

<table>
<thead>
<tr>
<th>Name of drug</th>
<th>mg dose</th>
<th># tablets</th>
<th># times per day</th>
<th>Name of drug</th>
<th>mg dose</th>
<th># tablets</th>
<th># times per day</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Over the counter medicines (Aspirin, Tylenol, Ibuprofen, Aleve, vitamins and herbals)

__________________________
__________________________
__________________________
__________________________

Family History

Father Living Deceased Illness Cause of Death/Age

Mother Living Deceased Illness Cause of Death/Age

Sister (s) Living Deceased Illness Cause of Death/Age

Brother (s) Living Deceased Illness Cause of Death/Age

Other Family History: Yes No Family Member

1. Heart Disease Yes No Family Member 5. Osteoporosis Yes No Family Member
2. Cancer (type) Yes No Family Member 6. Thyroid Problems Yes No Family Member
3. Diabetes Yes No Family Member 7. Endometriosis Yes No Family Member
4. Alcohol abuse Yes No Family Member 8. Other Yes No Family Member

Social History

Smoke? Yes No If yes, # packs per day: ___________ # of years: ___________

Alcohol? Yes No If yes, how many drinks per week? ___________

Coffee - How much ___________ Tea - How much ___________

Soda – How much