

**MEDICAL HISTORY**

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_ DATE: \_\_\_\_\_

BIRTHPLACE: \_\_\_\_\_ MARRIED \_\_\_ SINGLE \_\_\_ WIDOWED \_\_\_ OCCUPATION: \_\_\_\_\_

**FAMILY HISTORY:**

	NAME	AGE IF LIVING	AGE OF DEATH IF DECEASED	ILLNESSES
FATHER:				
MOTHER:				
BROTHERS & SISTERS:				
1.				
2.				
3.				
4.				
5.				
HUSBAND OR WIFE:				
SONS & DAUGHTERS:				
1.				
2.				
3.				
4.				
5.				

**SOCIAL HISTORY:**

HAVE YOU EVER SMOKED? YES \_\_\_ NO \_\_\_ # OF PACKS PER DAY \_\_\_\_\_ # OF YEARS \_\_\_  
 DO YOU STILL SMOKE? YES \_\_\_ NO \_\_\_ If applicable, WHEN DID YOU QUIT SMOKING? \_\_\_\_\_  
 DO YOU DRINK? YES \_\_\_ NO \_\_\_ TYPE \_\_\_\_\_ AMOUNT \_\_\_\_\_  
 HOW OFTEN? \_\_\_\_\_  
 HOSPITALIZATION: YES \_\_\_ NO \_\_\_ WHEN? \_\_\_\_\_  
 WHERE? \_\_\_\_\_  
 HAVE YOU EVER HAD A BLOOD TRANSFUSION? YES \_\_\_ NO \_\_\_  
 ALLERGIES: FOODS: \_\_\_\_\_  
 DRUGS: \_\_\_\_\_  
 OTHERS: \_\_\_\_\_

**OBSTETRIC HISTO RY:**

AGE AT FIRST PERIOD: \_\_\_\_\_ AGE PERIODS STOPPED: \_\_\_\_\_ CONTRACEPTIVE USE: YES/NO HOW LONG \_\_\_\_\_  
 NUMBER OF PREGNANCIES: \_\_\_\_\_ NUMBER OF BIRTHS: \_\_\_\_\_  
 HAVE YOU HAD A HYSTERECTOMY: YES/NO WERE YOUR OVARIES REMOVED? YES/NO  
 HAVE YOU EVER TAKEN HORMONE REPLACEMENT THERAPY? YES/NO IF SO, HOW LONG: \_\_\_\_\_