INITIAL PATIENT MEDICAL HISTORY **Date ____ /____ /_____**

Patient Name _____

Last First MI

DO YOU CURRENTLY HAVE OR HAVE YOU EVERY HAD ANY OF THE FOLLOWING

	NO	YES
Diabetes	☐	☐
High Blood Pressure	☐	☐
Heart Disease	☐	☐
Asthma / Pulmonary Problems	☐	☐
Kidney / Bladder Problems	☐	☐
Intestinal Problems	☐	☐
Hepatitis	☐	☐
Clots in Veins	☐	☐
Thyroid Problem (Hypo / Hyper)	☐	☐
Cancer - Type _____	☐	☐
History of Abnormal Pap	☐	☐

Other or explain any "Yes" answers:

_____
_____
_____
_____
_____
_____

DO YOU CURRENTY HAVE ANY OF THE FOLLOWING

	NO	YES
Severe Persistent Headaches	☐	☐
Visual Difficulty	☐	☐
Poor Coordination	☐	☐
Dizziness	☐	☐
Fainting	☐	☐
Nausea / Vomiting	☐	☐
Vomiting Blood	☐	☐
Coughing Up Blood	☐	☐
Abdominal Pain	☐	☐
Diarrhea	☐	☐
Bloody Stools	☐	☐
Chest Pain	☐	☐
Shortness of Breath	☐	☐
Loss of Urine with Cough	☐	☐
Loss of Urine with Sneezing	☐	☐
Pain with Urination	☐	☐
Bloody Urine	☐	☐

Family History (Blood Relatives Only)
If "Yes" to Any Question - List Relationship to Patient

	NO	YES	Relationship - Maternal or Paternal
Diabetes	☐	☐	_____
High Blood Pressure	☐	☐	_____
Heart Disease	☐	☐	_____
Lung / Pulmonary Problems	☐	☐	_____
Kidney / Bladder Problems	☐	☐	_____
Intestinal Problems	☐	☐	_____
Seizures	☐	☐	_____
Thyroid Problems (Hypo /Hyper)	☐	☐	_____
Blood Problems	☐	☐	_____
Genetic Problems	☐	☐	_____
Down Syndrome	☐	☐	_____
Cancer - Type _____	☐	☐	_____

Other (Note any history of breast, ovarian, cervical or endometrial cancer)

_____
_____
_____
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