Your Past or Present Illness	Yes	No
No known medical problems □		
Abnormal Pap smear		
Anemia		
Autoimmune disorder		
Bladder infections		
Blood transfusions		
Breast cancer		
Deep Vein Thrombosis/BloodClot		
Diabetes Type:_____		
Endometriosis		
Fibroid uterus		
Heart disease or murmur		
Hepatitis		
High blood pressure		
Migraine headaches		
Ovarian cancer		
Pulmonary embolus		
Recurrent UTI		
Respiratory problems/Asthma		
Stomach or bowel problems		
Thyroid Disease		
Uncontrolled loss of urine		
Uterine cancer		

Family history of	Relationship
No known medical problems □	
Alcoholism	
Autoimmune disorder	
Birth defects/ hereditary disease	
Bleeding problems	
Breast cancer	
Cervical cancer	
Colon cancer	
Congenital heart disease	
Coronary artery disease	
Cystic fibrosis	
Depression	
Diabetes	
Down's syndrome	
Genital cancer	
Heart disease	
High blood pressure	
Osteoporosis	
Ovarian cancer	
Thyroid disease	
Other:	
Other:	

Please list any prescribed medications you are currently taking: **□ None**

Name	Dose	Name	Dose

Please list any non-prescribed/over the counter medications you are currently taking: **□ None**

Name	Name

Please list any drug allergies you have: **□ None**

Name	Reaction	Name	Reaction