

Past Surgical History

Please list any surgical procedures you have undergone:

Year	Surgery/Procedure

Family Medical History

	Age	Health	Age at Death	If deceased, cause	Comments
Father					
Mother					
Siblings					

Has any blood relative ever been diagnosed with any of the following conditions?

<input type="checkbox"/>	Alzheimer's	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	Bleeding Disease
<input type="checkbox"/>	Mental Disorder	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Cancer

Reproductive History (Females Only)

Number of Children:	Last Menstrual Period:
Hysterectomy? Yes / No If yes, when:	Birth Control:

Review of Systems

Please indicate those items that you are currently experiencing or have recently experienced:

<input type="checkbox"/>	Weight Change	<input type="checkbox"/>	Vision Change	<input type="checkbox"/>	Blurred Vision	<input type="checkbox"/>	Hearing Aides	<input type="checkbox"/>	Hearing Loss
<input type="checkbox"/>	Sinus Problem	<input type="checkbox"/>	Nose Bleed	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	Heart Palpitations	<input type="checkbox"/>	Shortness of Breath
<input type="checkbox"/>	Cough	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Loss of Appetite	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	Vomiting
<input type="checkbox"/>	Fever	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	Frequent Urination	<input type="checkbox"/>	Pain w/ Urination
<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	Weakness of muscle	<input type="checkbox"/>	Back pain	<input type="checkbox"/>	Change in skin color or moles
<input type="checkbox"/>	Rash	<input type="checkbox"/>	Breast Lump	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Numbness	<input type="checkbox"/>	Tremors

Is there anything else you feel the doctor should know about you and/or your medical history?