Name____________________ Date__________

Write Yes or No in the square at the left of the column if the item applies to you. Give any necessary details in the space to the right of the column.

HAVE YOU EVER HAD AN OPERATION ON ANY OF THE FOLLOWING? (Give dates if known)

	Appendix			Breast	
	Gallbladder			Ovary	
	Kidney Stones			Tubes	
	Tonsils			Uterus	
	Tumors			Vagina Repair	
	Varicose Veins			Caesarean Section	
	Hernia			D & C	
	Hemorrhoids			Cautery of Cervix	
	Chest			Conization of Cervix	
	Spine			Other	

PAST ILLNESSES: (Again, write yes or no and give details.)

	Measles			Asthma	
	Mumps			Ulcers, Reflux, Stomach Problems	
	Chicken Pox			Heart Disease	
	German Measles			Kidney Disease	
	Poliomyelitis			Epilepsy	
	Rheumatic Fever			Mental Disease/Depression	
	Cancer			Sexually Transmitted Disease	
	Tuberculosis			Diabetes	
	Allergies			Thyroid Disease	
	Drug Sensitivities			Blood Transfusion	
	Blood Disease			High Blood Pressure	
	Yellow Jaundice			Varicose Veins	
	Liver Disease			Phlebitis	
	Anemia			Others (Specify) (i.e. autoimmune diseases)	

FAMILY HISTORY: Have your grandparents, parents, brothers, sisters, uncles, aunts, or children ever been treated for:

	Melanoma			High Blood Pressure	
	Breast Cancer			Stroke	
	Ovarian Cancer			Osteoporosis	
	Colon Cancer			Depression	
	Cancer - Other			Parents Living?	
	Heart Disease			If deceased, give age and cause of death.	
	Kidney Disease			Sisters: Number Living?	
	Diabetes			Brothers: Number Living?	