

Name: _____ DOB: ___/___/___ Today's Date: _____

Sex: M F Marital Status: _____ Occupation: _____ Education: ___ years in school

Last doctor: _____ Allergies: _____

Past Medical History: (check all that apply)

- Cancers: _____ Lung Disease: _____
 Heart Disease: _____ Kidney Disease: _____
 Liver Disease: _____ Others: _____

Female Gynecological History (Menstrual history, contraception) _____

Pregnancies: _____ Births: _____ Last Menstrual Period: _____ Menopausal

Operations (*type & when*): _____

Hospitalizations other than for surgery (*reason & when*): _____

Tests: HIV Test: _____ Genetic Tests: _____ Other Tests: _____

Family History of: Father/Mother/Sister(s)/Brother(s)/Son(s)/Daughter(s)/Grandparent(s) (if yes, please expand as to who the family member is; also specify what type of cancer, if possible)

	Yes	No	Details
Hypertension			
Heart Disease			
Diabetes			
High Cholesterol			
Stroke			
Asthma			
COPD/Emphysema			
Tuberculosis			
Anemia			
Epilepsy			
Kidney Disease			
Liver Disease			
Cancer			
Psychiatric			
Substance Abuse			
Other			

