Have you had any of the following illnesses?

____ Chickenpox ____ Smallpox ____ German Measles ____ Hard Measles ____ Diptheria

____ Mumps ____ Scarlet Fever ____ Strep Throat

WOMEN:

Check if you have had problems with:

_____ Breast Lumps

_____ Discharge from nipples

_____ Vaginal discharge

_____ Uterine Infection

____ Menstrual period

Bleeding between periods

Did your mother take DES

Age when you had your first period__________

Average number of days of flow __________

Length of time between periods __________

Number of pregnancies __________

Number of live births _______

Number of miscarriages __________

Number of abortions __________

Number of living children __________

Do you think you are pregnant now? ________

Date of last Pap Smear ______

Date of last mammogram ______

Have you ever had an abnormal pap smear or mammogram? ____

____

____

____

Do you regularly perform self breast exams? __________

MEN:

Check if you have had problems with:

_____ Urination _____ Testicular Pain or Swelling _____ Prostate trouble _____ Impotence

Do you regularly perform testicular exams? __________

FAMILY HISTORY	LIVING	DECEASED	AGE	HEALTH PROBLEMS OR CAUSE OF DEATH
Father				
Mother				
Brother or Sister 1				
2				
3				
4				
5				
Husband or Wife				
Children 1				
2				
3				
4				
5				

Has any blood relative ever had	Please circle no or yes	Who (relationship)
Tuberculosis	no yes	
Asthma	no yes	
Stroke	no yes	
Diabetes	no yes	
Heart disease	no yes	
High blood pressure	no yes	
Kidney disease	no yes	
Cancer, where?	no yes	
Migraine	no yes	
Epilepsy	no yes	
Mental Illness	no yes	
Thyroid trouble (goiter)	no yes	
Anemia	no yes	

SOCIAL HISTORY:

Do you smoke? ________ If so, how much? Cigarettes ______/packs per day ______Cigars per day______ Pipe

Do you drink? __________ Liquor ______ Beer _______ If so, how much? __________

Do you use illegal drugs? __________ If so, what kind, how much? __________

Have you ever been treated for alcohol or substance abuse? __________ If so, how long ago? __________

Do you drink caffeinated beverages (coffee, cola) ________ If so, how much? __________

How often do you exercise? YES NO

Do you eat a low fat diet? YES NO

Do you wear seat belts when you are in a car? YES NO

Do you wear a helmet when riding a bike or motorcycle? YES NO

Do you have smoke detectors in your home? YES NO

Are you often dissatisfied with your work? YES NO

Are you tense or fearful? YES NO

Are you often dissatisfied with your sexual life? YES NO

Are you sad or depressed? YES NO

Do you ever feel like "ending it all"? YES NO

COMPLETE PHYSICAL EXAM RECOMMENDED YES NO

Physician Signature Date