<table>
<thead>
<tr>
<th>Month/Year</th>
<th>Illness or Operation</th>
<th>Complications</th>
</tr>
</thead>
<tbody>
<tr>
<td>/</td>
<td></td>
<td>Yes</td>
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<td>Yes</td>
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<td>Yes</td>
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</tbody>
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<table>
<thead>
<tr>
<th>MEDICAL HISTORY (Check appropriate boxes)</th>
<th>You</th>
<th>Family</th>
</tr>
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</table>
1. High Cholesterol                       |     |        |
2. Heart Disease                          |     |        |
3. High Blood Pressure                     |     |        |
4. Asthma/Lung Disorder                    |     |        |
5. Mitral Valve Prolapse                   |     |        |
6. Diabetes                                |     |        |
7. Thyroid Problems                        |     |        |
8. Headaches/Migraines                     |     |        |
9. Nervous Disorder or Depression          |     |        |
10. Liver Disease                          |     |        |
11. Stomach, Bowel, or Gallbladder Problems|     |        |
12. Kidney or Bladder Problems             |     |        |
13. AIDS (HIV)                             |     |        |
14. Hepatitis (Type: ____ )                |     |        |
15. Anemia or Blood Disorder               |     |        |
16. Blood Transfusion                      |     |        |
17. Breast Problems                        |     |        |
18. Cancer                                 |     |        |
19. Fertility                              |     |        |
20. Female or Sexual Problems              |     |        |
21. Chlamydia, Gonorrhea, or Herpes        |     |        |
22. Syphilis                               |     |        |
23. Birth Defects or Inherited Diseases    |     |        |
24. Sexual Abuse or Domestic Violence      |     |        |
25. Other Medical Problems                 |     |        |
26. No Known Medical Problems              |     |        |
27. Immunizations up-to-date               |     |        |
28. Last Pap Smear                         |     |        |
29. History of abnormal Pap Smears?        |     |        |
| If yes, when and where treated:          |     |        |
30. Last mammogram? (Date/Place)          |     |        |
31. History of abnormal mammogram readings?|     |        |

<table>
<thead>
<tr>
<th>SUBSTANCE USE (Circle only those used)</th>
</tr>
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</table>
32. Alcohol: Type: ___________________ Amt: ______________ |
33. Tobacco: Type: ___________________ Amt: ______________ |
34. Street Drugs: Type: ______________ Amt: ______________ |

Number of Pregnancies: ______
Number of Miscarriages: ______
Number of Abortions: ______