MEDICAL HISTORY

Name	PLEASE PRINT	THIS INFORMA	ATION BECOMES PA	RT OF YOUR CONFIDENT	TIAL MEDICAL REC	CORD P	LEASE PRINT	
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Dog	Madical History & De	oviov. c	of Cystoms								
Past Medical History & Review of Systems Please check if you have had problems with or are presently complaining of any of the following:											
1 ICa	se effect if you have had pr	obicins v	with of are presently compla	illing o	i any (or the ron	owing.				
1.	□ High Blood Pressure	14.	□ Pneumonia	27.		explained	Weight	40.	□ Skin Disease		
2.	□ Diabetes	15.	□ Persistent Cough	Loss/Gain 28. □ Hemorrhoids				41.	□ Blood Disorders		
3.	8		□ T.B.	29.				42.	□ Venereal Disease		
4.			□ Hay Fever	30.				43.	□ Anxiety		
5.	□ Chest Pain/Chest	18.	□ Abdominal Discomfort	31.	31. Hepatitis or Jaundice			44.	□ Depression		
	Tightness					F			r		
6.	□ Shortness of Breath	19.	□ Indigestion	32.	□ Th	yroid Dise	ease	45.	□ Anemia		
7.	□ Swollen Ankles	20.	□ Nausea	33.			k Radiation	46.	□ Alcohol Abuse		
8.	□ Palpitations	21.	□ Vomiting	34.		adache		47.	□ Drug Abuse		
9.	□ Light-headedness	22.	□ Constipation	35.		dney Disea	ase	48.	□ Gout		
10.	□ Frequent Urination	23.	□ Diarrhea	36.		dney Stone		49.			
11.	□ Rheumatic Fever	24.	□ Blood in Stool	37.				50.			
12.	□ Asthma	25.		38.		thritis	manng		HER:		
13.	□ Bronchitis	26.	☐ Change in Bowel Habits	39.		w Back Pi	oblems	011	ILIK.		
10.	- Dionemus	20.	- Change in Dowel Habits		- Lo	W Buck II	oolems				
 											
Dro	vention										
110	CHUOH										
_	4. 1. 0				N	37	ICAL XXII AL	.0			
До у	ou wear seatbelts?				No	Yes	If No, Why No	ot? _			
Do you wear a bike helmet?					No	Yes	N/A				
If the	ere is a gun in your home, is	s it out o	f children's reach &		NI.	Van	NI/A				
	aded?				No	Yes	N/A				
Do you use drugs? (Marijuana, Cocaine, Crack, etc.)					No	Yes	If yes,				
			, Clack, Etc.)		110		explain:				
Have you ever engaged in any activity				No	Yes	If yes,					
which has put you at risk of getting AIDS?				-		explain:					
Do you wish to be tested for AIDS?				No	Yes						
Have you ever worked with chemicals, paints, asbestos, or other					T 7	If yes,					
hazardous materials?					No	Yes	explain:				
Are	you in a relationship in whi	ch vou h	ave been physically hurt			•	1				
(E.G., slapped, kicked, punched, buised) by your partner?				No	Yes						
-	ou feel afraid of your partn		•••		No	Yes					
	• •				-						
	ou have a living will?				No	Yes					
Do y	ou have a donor card?				No	Yes					
					-						
FΟ	R WOMEN ONLY			Num	her c	of Pregna	ancies				
				1		_					
	e Last Menstruated?					of Misca					
Period every Days.					Birth Control Method (if any)						
Any	Menstrual Problems?		Yes No	Date of Last Pap Smear							
_	vy Periods			Check if you have had:							
				Circ			ilaa.		Toward		
Irregular Periods						D&C			Toxemia		
Infrequent Periods						Hystere	ctomy		Cesarean sec.		
Pair	nful Periods			Difficulty with pregnancy							
	tting			With labor							
Discharge											
Discharge						With delivery					