

Medical History Form (Women)

First Name: _____ Last Name: _____

Do you currently have any of these symptoms? If you do

<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Depression	<input type="checkbox"/> Irregular Heart Beat	<input type="checkbox"/> Rash
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Joint Pain	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Back Pain	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Leg Swelling	<input type="checkbox"/> Sore Throat
<input type="checkbox"/> Breast Lump	<input type="checkbox"/> Earache	<input type="checkbox"/> Menstrual Problems	<input type="checkbox"/> Swollen Glands
<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Easy Bruising	<input type="checkbox"/> Mole Changes	<input type="checkbox"/> Urinary Frequency
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Nasal Congestion	<input type="checkbox"/> Vaginal Discharge
<input type="checkbox"/> Chills	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Nausea	<input type="checkbox"/> Vomiting
<input type="checkbox"/> Constipation	<input type="checkbox"/> Fever	<input type="checkbox"/> Numbness	<input type="checkbox"/> Weight Loss
<input type="checkbox"/> Cough	<input type="checkbox"/> Headaches	<input type="checkbox"/> Pelvic Pain	<input type="checkbox"/> Wheezing

Please list all previous medical problems: None

Please list any surgeries or medical procedures that you have had (include dates): None

Do you have any allergies to medication? No Yes (If yes, please list the specific medication(s) and the type of reaction you had): _____

Please list diseases which run in your family (include relationship, e.g. Mother, Father etc.):

How much tobacco do you smoke? None under 1 pack/day 1 pack/day Over 1pack/day

How much alcohol do you drink? None Moderate (1 drink/day or less) Heavy (over 1 drink/day)

Do you have a substance abuse history? Yes No

If yes, please explain: _____

Please list your current medications (include dose and frequency): None

Check if you are: Pregnant Nursing