PAST AND PRESENT MEDICAL PROBLEMS

Check (✓) all items either yes or no and give approximate date if past.	No	Yes Now	Yes Past	If Past Date
Asthma				
Abnormal Electrocardiogram				
Angina				
Anemia (Type)				
Arthritis				
Blindness Either Eye				
Broken Bones				
Cataracts				
Chronic Bronchitis/Chronic Lung Disease				
Cirrhosis of Liver				
Colon or Bowel Trouble				
Deafness				
Dysentery				
Diabetes				
Ear Infections				
Emphysema				
Enlarged Heart				
Glaucoma				
Gall Stones				
Gout				
Goiter				
Gonorrhea				
Hay Fever				
Heart Murmur as Adult				
Heart Attack				
High Blood Pressure				
Hepatitis				
Hemorrhoids				
Kidney Infection				
Kidney Stones				
Nervous Breakdown				
Poor Blood Clotting				
Polio				
Phlebitis				
Rheumatic Fever				
Rectal Trouble				
Recurrent Boils				
Stroke				
Stomach or Duodenal Ulcer				
Syphilis				

Check (✓) all items either yes or no and give approximate date if past.	No	Yes Now	Yes Past	If Past Date
Skin Disease				
Serious Depression				
Serious Emotional Problems				
Tuberculosis				
Thyroid (overactive)				
Thyroid (underactive)				
Varicose Veins				
Men				
Prostate Problems				
Women				
Menstrual Difficulties				
Cystitis				
Mastitis				
Ovarian Cyst				
Breast Cancer				
Other Breast Disease*				
Other Gynecological Problems*				
Still Menstruating				

Age Period Started ______________

Age Periods Stopped ______________

Why Periods Stopped ______________

Number of Pregnancies ______________

Number of Children ______________

Number of Miscarriages ______________

*Explain:

Hospitalizations/Reason   Date

Do you wear artificial devices? Yes No

Please list

Do you have allergies? Yes No

Please list

Doctor's Use Only — Summary