GREG HEAL, M.D.

Name _____ Date _____

No. of Preg.	Date of Birth	Length of Preg.	Birth Weight	Sex	Length of Labor	Complications
1						
2						
3						
4						
5						

Briefly list your complaints: _____

_____

_____

At what age did you start menstruating? _____

How long do your periods last? _____ How often do your periods occur? _____

Contraceptive use — past and present _____

About how many pads/tampons do you use during each menstrual period? _____

Do you bleed between periods? _____

First day of last menstrual period. _____ Last Mammogram:

Date of last pap smear. _____ Last Colonoscopy:

List all operations you have had and approximate dates:

List all serious illnesses you have had and approximate dates:

List all medications you are taking:

Are you allergic to any medications? _____ Please List:

How many cigarettes do you smoke per day?

FATHER: ☐ Living ☐ Dead Age _____ MOTHER: ☐ Living ☐ Dead Age _____

Cause of Death _____ Cause of Death _____

How many brothers and sisters are living? _____ Are deceased? _____

List causes of death: _____

Does anyone in your family have diabetes, cancer, epilipsy, tuberculosis or heart disease? _____

Do you drink alcohol? _____ How often? _____