PATIENT HISTORY

Name ______________________________ **DOB:** ______________________

Medication Allergies: ____

Daily Prescription Medications: _______________________________________

Current Medical Conditions:

Surgeries: Date Operation Date
Operation

________________________________ ____________________________

________________________________ ____________________________

Other Hospitalizations (excluding childbirth)
Reason Date Reason Date

________________________________ ____________________________

________________________________ ____________________________

Please circle you answer below and explain as needed

Pregnancies: None Number of Pregnancies _____ Number of Live Births_____
Abnormal Pap Smear: no yes (if YES, have you had a colposcopy___ surgery ______
Cigarettes: Never smoked Currently Smoke ____packs per day Quit/date____
Alcohol Consumption: never occasional weekly daily: # per day ______
Any history of drug use: none other __________________________

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Family History of Cancer (breast, ovarian, colon or uterine) NONE

Yes, relationship _______________ Type of cancer ___________________ Age_________

Relationship__________________Type of cancer___________________ Age_________

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