FAMILY HISTORY:

		If Living		If Deceased	
		Age	Health Condition	Age	Cause of death
Father		_____/_____		_____/_____	
Mother		_____/_____		_____/_____	
Brothers/Sisters	1.	_____/_____		_____/_____	
	2.	_____/_____		_____/_____	
	3.	_____/_____		_____/_____	
Son/Daughter	1.	_____/_____		_____/_____	
	2.	_____/_____		_____/_____	
	3.	_____/_____		_____/_____	

GYNECOLOGICAL HISTORY:

Age of first period: _____

Date of last period: _____

Has your uterus been removed? _____

Have your ovaries been removed? _____

How many times have you been pregnant? _____

How many children have you had? _____ Twins: _____

How old were you when you had your first child? _____

Did you breast feed? _____

SOCIAL HISTORY:

Are you Single _____ Married _____ Divorced _____ Widow(er) _____

(optional) Are you homosexual _____ Heterosexual _____ Bisexual _____

Occupation: _____

HABITS:

Alcoholic Beverages: Never Rarely Moderately Daily

Tobacco: Do you smoke? _____

How many packs per day? _____

For how long? _____

Date you last smoked, if you have ever smoked: _____

Drugs: Marijuana Cocaine Amphetamines Other: _____

Have you ever been treated for alcoholism or drug abuse? _____

If yes, dates: _____