



## PAST AND PRESENT MEDICAL PROBLEMS

Check (✓) all items either Yes or No and give approximate date if past. <b>Provide details for all YES answers in the space provided below.</b>		No	Yes Present	Yes Past	If Past, Date	Check (✓) all items either Yes or No and give approximate date if past. <b>Provide details for all YES answers in the space provided below.</b>		No	Yes Present	Yes Past	If Past, Date
Allergy						Poor Blood Clotting					
Asthma						Polio					
Abnormal EKG						Rheumatic Fever					
Anemia (Type: _____ )						Rectal Trouble					
Arthritis						Recurrent Boils					
Blindness Either Eye						Sexually Transmitted Disease					
Broken Bones						Stroke					
Cancer/Tumor						Stomach or Duodenal Ulcer					
Cataracts						Skin Disease					
Chest Pain						Thrombophlebitis					
Chronic Bronchitis/Chronic Lung Disease						Tuberculosis					
Cirrhosis of Liver						Thyroid overactive					
Colon/Bowel Trouble						Thyroid underactive					
Deafness						Varicose Veins					
Depression						<b>Men</b>					
Diabetes						Prostate Problems					
Diarrhea						Urinary Problems					
Ear Infection						Sexual Problems					
Emotional Problems						<b>Women</b>					
Emphysema						Menstrual Difficulties					
Enlarged Heart						Bladder Infection					
Glaucoma						Sexual Problems					
Gallstones						Ovarian Cyst					
Gout						Breast Cancer					
Goiter						Other Breast Disease					
HIV						Other Gyn. Problems					
Hay Fever						Birth Control					
Heart Murmur as adult						Still Menstruating					
Heart Attack						Age Periods Started _____					
High Blood Pressure						Age Periods Stopped _____					
Hepatitis						Last Pap Smear _____					
Hemorrhoids						Last Mammogram _____					
Kidney Infection						No. of Pregnancies _____					
Kidney Stones						No. of Children _____					
Nervous Breakdown						No. of Miscarriages/Abortions _____					

**Details:** Please provide further information of any medical problems

**(Doctor's Use Only - Summary)**