

(MEDICAL HISTORY CONTINUED)

MR # _____

List any prior surgeries

SURGERY	DATE (Approximate month/year)

REPRODUCTIVE HISTORY FOR WOMEN:

- Approximately at what age did you begin having periods? _____
- How many children have you had? _____
- How old were you when your first child was born? _____
- Have you had any miscarriages? Yes No If yes, how many? _____
- Have you gone through menopause? Yes No If yes, approximately how old were you? _____
- Have you had a hysterectomy? _____
- If yes, how old were you? _____ Were your ovaries removed? _____
- Have you at any time taken hormone replacement therapy? _____
- If yes, what did you take and for how long? _____

4. FAMILY HISTORY:

List any major illnesses that run in your family.

ILLNESS	RELATIONSHIP

HABITS

- Do you smoke or have you ever smoked cigarettes? _____
- If yes, how much and for how long? _____
- If you have quit smoking, when did you quit? _____
- Do you use other tobacco products? _____
- Do you drink alcohol? _____
- If yes, how much and how often? _____