



**(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? \_\_\_\_\_