PAST MEDICAL HISTORY (Not OB/gyn) I

Check any that apply: or 105. ☐ None

106. ☐ Arthritis
107. ☐ Diabetes: 108. a) ☐ Diet controlled
109. b) ☐ Pill controlled
110. c) ☐ Insulin controlled
111. ☐ High blood pressure
112. ☐ Heart disease
113. ☐ Kidney Disease
114. ☐ Gallstones
115. ☐ Liver Disease (including hepatitis)
116. ☐ Epilepsy
117. ☐ Blood Transfusions
118. ☐ Thyroid disease
119. ☐ Asthma
120. ☐ Emphysema
121. ☐ Bronchitis
122. ☐ HIV+
123. ☐ Eating Disorder
124. ☐ Other

CURRENT MEDICATIONS (include dose (amount) per day) J

125. ☐ None _____
126. ☐ for diabetes _____
127. ☐ for blood pressure _____
128. ☐ for thyroid _____
129. ☐ for infection _____
130. ☐ for sleep _____
131. ☐ for pain _____
132. ☐ for heart _____
133. ☐ for ulcers _____
134. ☐ for epilepsy _____
135. ☐ for fluid retention _____
136. ☐ for asthma _____
137. ☐ for allergy _____
138. ☐ for depression _____
139. ☐ for anxiety _____
140. ☐ hormonal _____ (include birth control pills)
141. ☐ for skin _____
142. ☐ Other _____

DO YOU CURRENTLY?: K

143. Smoke No ☐ Yes ☐ _____ packs/day
144. Use alcohol No ☐ Yes ☐ _____ (189.) wine (glasses/day); _____ (145.) beer (bottles/day); _____ (146.) hard liquid (oz./day)
147. Use illicit drugs No ☐ Yes ☐ _____ (type) _____ (amount)
148. Exercise: Type _____ How often _____

DRUG ALLERGIES L

149. No ☐ Yes ☐ List: _____

FAMILY HISTORY M

150. ☐ Diabetes 151. ☐ Heart Disease 152. ☐ Breast Cancer 153. ☐ Other _____
154. ☐ Ovarian Cancer 155. ☐ Endometrial Cancer 156. ☐ Colon Cancer _____

If "yes" for 150-156, please list affected relatives _____

157. ☐ None of the above

OTHER SYMPTOMS N

Have you had recent?:

158. ☐ weight loss
159. ☐ weight gain
160. ☐ change in energy
161. ☐ change in exercise tolerance
162. ☐ hair growth
163. ☐ hair loss
164. ☐ change in urinary fucntion
165. ☐ hot flushes/flashes
166. ☐ breast discharge
167. ☐ none of the above
168. ☐ other _____