Does your mother or father have any of the following? Check "M" or "F"

High Blood Pressure	___M ___F	Cancer: ______________________	___M ___F
Anemia	___M ___F	Crohn's Ulcerative Colitis	___M ___F
Lung Problems/COPD	___M ___F	CVA/Stroke	___M ___F
Coronary Artery Disease	___M ___F	Diabetes	___M ___F
Congestive Heart Failure	___M ___F	High Cholesterol/Lipids	___M ___F
GERD	___M ___F	Thyroid Problems	___M ___F

Do you have any of the following?

Anemia	___Y ___N	COPD	___Y ___N
Atrial Fibrillation	___Y ___N	Coronary Artery Disease	___Y ___N
Cancer: _______________	___Y ___N	Congestive Heart Failure	___Y ___N
Cirrhosis	___Y ___N	Crohn's/Ulcerative Colitis	___Y ___N
Kidney Failure/Problems	___Y ___N	Stroke	___Y ___N
Diabetes Type 1 or 2	___Y ___N	Gastric Reflux Disease	___Y ___N
Hepatitis	___Y ___N	High Cholesterol	___Y ___N
High Blood Pressure	___Y ___N	Thyroid Problems	___Y ___N
Heart Attack	___Y ___N	Tuberculosis	___Y ___N
Osteoarthritis	___Y ___N	Rheumatoid Arthritis	___Y ___N
Osteoporosis	___Y ___N	Stomach Ulcer	___Y ___N

Surgical History

Appendectomy	___Y ___N	Gall Bladder	___Y ___N
Breast Lumpectomy	___Y ___N	Heart Surgery	___Y ___N
Hernia	___Y ___N	Hysterectomy	___Y ___N
Mastectomy	___Y ___N	Ovary	___Y ___N
Hemorrhoid	___Y ___N	Tubal Ligation	___Y ___N
Tonsil/Adenoids	___Y ___N		

Social History

Smoker	___Y ___N	Alcohol	___Y ___N
Date Quit: _________________________		Caffeine Use	___Y ___N

Packs Per Day _____________________

How Many Years? __________________

Breast Patients

Menopause	___Y ___N	Hormones/Birth Control Pills	___Y ___N

Last Menstrual Period: ____________

Preventive Care

Last Colonoscopy: ___________________ Last Stress Test: ______________________________
Last Mammogram: __________________ Last Flu Shot: _________________________________

List any other health issues here:____
____
____