Medications you are currently taking (including birth-control pills, aspirin, laxatives): Please list names, strengths, and frequency:_____
_____
_____
_____

Please list any drug allergies:_____

PAST MEDICAL HISTORY: List the names and approximate dates of any serious illnesses, accidents, hosptializations, or surgery you have had:

1._____
_____
2._____
_____
3._____
_____
4._____
_____
5._____
_____

Write in the dates of the last time you can recall having had the following vaccinations:

Tetanus:_____
Influenza ("Flu shot")_____
Pneumonia ("Pneumovac")_____

Have you ever been told you have high cholesterol?_____
Do any family members have high cholesterol?_____

FOR WOMEN ONLY:

Date of the first day of your last menstrual period:_____
Date of your last pap smear:_____
Write in the dates of all pregnancies:_____
_____
Have you ever had a mammogram (breast view)?_____
Date of most recent mammogram:_____
Do you regularly check your breasts for lumps (breast self-exam)?_____
Has any family member had breast cancer?_____
Has any family member had osteoporosis?_____

THANK YOU!