# YOUR MEDICAL HISTORY

NAME_____ DATE _____
LAST FIRST MI

PRIMARY CARE PHYSICIAN _____
NAME NUMBER

PLEASE LIST:
ALLERGIES TO MEDICATIONS OR SUPPLEMENTS: _____
ANY OTHER ALLERGIES: _____
REACTIONS TO MEDICATIONS: _____

WHEN DID YOU LAST HAVE THE FOLLOWING:
PHYSICAL EXAM: _____
EKG: _____
CHEST X-RAY: _____
BLOOD WORK: _____
T-CELL COUNT: _____

## YOUR PAST SURGICAL HISTORY

PLEASE LIST ALL SURGERIES YOU HAVE HAD, BOTH COSMETIC AND NON-COSMETIC:

1. _____ DATE _____
2. _____ DATE _____
3. _____ DATE _____
4. _____ DATE _____
5. _____ DATE _____
6. _____ DATE _____
7. _____ DATE _____

PLEASE LIST INJURIES AND/OR HOSPITALIZATIONS:

1. _____ DATE _____
2. _____ DATE _____
3. _____ DATE _____

PLEASE LIST ALL CURRENT OR RECENT MEDICATIONS
(Please include all prescription, non-prescription, vitamins, and supplements):

1. _____ FREQUENCY _____
2. _____ FREQUENCY _____
3. _____ FREQUENCY _____
4. _____ FREQUENCY _____

## GYNECOLOGICAL HISTORY (IF APPLICABLE):

PLEASE GIVE YOUR NUMBER OF PREGNANCIES: _____
NUMBER OF NORMAL DELIVERIES: _____
NUMBER OF C-SECTIONS: _____
MISCARRIAGES/ABORTIONS: _____