AWARE WOMEN'S HEALTH

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Medical History

Please complete this form and return it to the rooms prior to, or at the time of your consultation.

DETAILS

Name:

Date:

Date of birth:

MEDICAL HISTORY

Number of pregnancies:

Number of children:

When was your last PAP smear?

Have you ever had a mamogram? Y/N

Have you experienced any of the following:

- ☐ Heart trouble
- ☐ Rheumatic fever
- ☐ Angina
- ☐ High blood pressure
- ☐ Stroke
- ☐ Asthma
- ☐ Shortness of breath
- ☐ Gastric ulcer
- ☐ Blood transfusion
- ☐ Smoker
- ☐ Thrombosis
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Bleeding tendency
- ☐ Hepatitis or other blood born infections

CURRENT PROBLEMS OR CONCERNS

Please outline your current problems or concerns:

FURTHER DETAILS

☐ Current medication, please specify:

☐ Contraception, please specify:

☐ Other illnesses, please specify:

☐ Surgery, please specify:

☐ Allergies, please specify:

☐ Are there any illnesses that run in your family? Please specify: