

Have you or a family member ever had....

Check both personal and family boxes	Personal		Family		Specify Family Member
	Yes	No	Yes	No	
Abnormal Pap Smear					
Allergies					
Anemia					
Asthma/Emphysema/Breathing problems					
Birth Defects					
Blood Transfusion					
Blood clots in a Leg or Lung					
Breast disease					
Cancer					
DES exposure					
Diabetes					
Ear, nose or throat problems					
Epilepsy/Seizures					
Gall Bladder Disorder					
Headaches – frequent or severe					
Heart Disease					
Hepatitis/ Liver Disease					
High Blood Pressure					
HIV					
Infertility					
Kidney Disease					
Mental Retardation					
Multiple Pregnancy (twins, triplets)					
Nervous Disorder (depression, anxiety)					
Sexually Transmitted Diseases					
Stroke					
Surgery / Complications (specify)					
T.B.					
Thyroid Disease					
Unusual Vaginal Disease					
UTI (Urinary Tract Infection)					
Hospitalization					
Major Accident / Trauma					
Do you use alcohol/drugs? Specify	YES	NO			
Do you smoke?	YES	NO			
If yes, How much?					
Date of last pap (circle)	Normal?	Abnormal?			

I certify that the above information has been completed truthfully to the best of my knowledge.

Signature _____ Date _____