

## PAST AND PRESENT MEDICAL PROBLEMS

Check (✓) all items either yes or no and give approximate date if past.	No	Yes Now	Yes Past	If Past Date	Check (✓) all items either yes or no and give approximate date if past.	No	Yes Now	Yes Past	If Past Date
Asthma					Skin Disease				
Abnormal Electrocardiogram					Serious Depression				
Angina					Serious Emotional Problems				
Anemia (Type _____)					Tuberculosis				
Arthritis					Thyroid (overactive)				
Blindness Either Eye					Thyroid (underactive)				
Broken Bones					Varicose Veins				
Cataracts					<b>Men</b>				
Chronic Bronchitis/Chronic Lung Disease					Prostate Problems				
Cirrhosis of Liver					<b>Women</b>				
Colon or Bowel Trouble					Menstrual Difficulties				
Deafness					Cystitis				
Dysentery					Mastitis				
Diabetes					Ovarian Cyst				
Ear Infections					Breast Cancer				
Emphysema					Other Breast Disease*				
Enlarged Heart					Other Gynecological Problems*				
Glaucoma					Still Menstruating				
Gall Stones					Age Period Started _____				
Gout					Age Periods Stopped _____				
Goiter					Why Periods Stopped _____				
Gonorrhea					Number of Pregnancies _____				
Hay Fever					Number of Children _____				
Heart Murmur as Adult					Number of Miscarriages _____				
Heart Attack					*Explain:				
High Blood Pressure									
Hepatitis									
Hemorrhoids									
Kidney Infection					Hospitalizations/Reason _____				Date _____
Kidney Stones									
Nervous Breakdown									
Poor Blood Clotting									
Polio					Do you wear artificial devices? Yes No				
Phlebitis					Please list _____				
Rheumatic Fever									
Rectal Trouble									
Recurrent Boils					Do you have allergies? Yes No				
Stroke					Please list _____				
Stomach or Duodenal Ulcer									
Syphilis									

**Doctor's Use Only — Summary**