

ASSIGNED FEMALE AT BIRTH THIS SECTION (Circle)

No Yes Have you had or have a blood relative with breast cancer?
No Yes Have you had a breast biopsy? When_____?
No Yes Have you had a mammogram within the last 2 years Result_____.

Do you have or have you had any of the following? Please circle and explain.

Skin: rash, ulcer, pigment changes, other_____

Eyes: glaucoma, cataracts, vision problems, eye pain, other_____

Ears, Nose, Throat: deafness, ringing in ears, deviated septum, sinus trouble, other_____

Lungs: cough, shortness of breath, asthma, emphysema, COPD, pneumonia, sleep apnea, other_____

Heart: chest pain, irregular heart beat, heart murmur, heart attack, pain or swelling of lower legs, varicose veins, dizziness, other _____
Have you had a stress test in the past? If yes, when was the test?_____

Gastrointestinal: nausea/vomiting, heartburn, acid reflux, abdominal pain, ulcer, gallbladder disease, liver disease, jaundice, rectal bleeding or blood in stool, diarrhea, other _____

Genitourinary: urinary trouble, blood in urine, prostate problems, kidney disease or failure, other_____

Musculoskeletal: back pain, spine problems, arthritis, muscle pain, joint pain, other_____

Neurological: headache/migraine, seizures, stroke, passing out, numbness or tingling, tremor, confusion, memory problems, paralysis, other _____

Psychiatric: mental illness, depression, anxiety, nervous breakdown, eating disorder, other_____

Blood/Lymph systems: anemia, excessive bleeding, easy bruising, Sickle cell disease or trait, swollen glands, bleeding gums, nosebleeds, other _____

Endocrine: thyroid problems, goiter, unwanted weight gain or loss, diabetes (sugar), excessive thirst, excessive urination, other_____

Are you presently taking any of the following medications? (Circle)

No Yes Aspirin	No Yes Tranquilizers	No Yes Antibiotics
No Yes Blood pressure pills	No Yes Thyroid medicine	No Yes Birth control pills
No Yes Prednisone	No Yes Arthritis medicine	No Yes Alka-seltzer
No Yes Cough Medicine	No Yes Headache pills	No Yes Sinus medicine
No Yes Digitalis, Digoxin	No Yes Weight reducing pills	No Yes Other drugs not listed
No Yes Hormones	No Yes Water pills	_____
No Yes Insulin, Diabetic pills	No Yes Blood thinners	_____
No Yes Iron pills	No Yes Dilantin	_____
No Yes Laxatives	No Yes Barbiturates	_____
No Yes Sleeping pills	No Yes Phenobarbital	_____

Signature: _____ Date: _____