

MEDICATIONS:

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

- | | | | | | |
|-----|----|--------------------------------|-----|----|---|
| Yes | No | Aspirin, Bufferin, Anacin | Yes | No | Tranquilizer |
| Yes | No | Blood pressure pills | Yes | No | Weight reducing pills |
| Yes | No | Cortisone | Yes | No | Blood thinning pills |
| Yes | No | Cough medicine | Yes | No | Dilantin |
| Yes | No | Digitalis (Heart pills) | Yes | No | Shots |
| Yes | No | Hormones | Yes | No | Water Pills |
| Yes | No | Insulin or diabetic pills | Yes | No | Antibiotics |
| Yes | No | Iron or poor blood medications | Yes | No | Barbiturates |
| Yes | No | Laxatives | Yes | No | Birth control pills, brand name: _____ |
| Yes | No | Sleeping pills | Yes | No | Phenobarbital |
| Yes | No | Thyroid medicine | Yes | No | Other drugs not listed. If so, please list. |

List the operations (major or minor) you have had as well as the hospital location and date: _____

Name any drugs to which you are allergic, and state the reaction you have had: _____

Write in the names of any diseases or illnesses you have now or had in the past: _____

Serious injuries or accidents: _____

MENSTRUAL HISTORY:

Age at onset of Menses _____ Duration of Menses _____ Interval between Menses _____

First day of last menstrual period: _____

(CIRCLE)

- Yes No Have you ever missed a period except when pregnant?
 Yes No Has your period ever lasted more than eight days or less than two days?
 Yes No Did you ever pass large clots during your period?

CONTRACEPTIVE HISTORY:

- Yes No Have you ever taken birth control pills?
 Yes No Are you presently taking birth control pills? Which one? _____
 Yes No If no, what form of contraception do you use? _____

