HISTORY FORM

Name: ____ SS#: _______________________

Address: ____

Phone: _____________ Fax: ___________________ E-mail: ______________________________

DOB: _____________ Marital Status: ________________ No. of Children: ____________________

Height: ___________________________ Weight: __________________ Bra Size: _____________

Occupation: ____

Do you smoke? ____Yes ____No ____If yes, how much? ___________________________________

Do you drink alcohol? ____Yes ____No ____If yes, how much? ______________________________

Please list any Allergies: ____

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Please list all medication including over the counter drugs, vitamins, herbal supplements you are taking:

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____

Medical History - Check all that apply:

_______ Heart Disease _______ Hypertension _______ Diabetes _______

Kidney disease _______ Asthma _______ Cancer

Other Past Surgeries (particular abdominal): ____

____

Any previous problems experienced with general anesthesia? ___________________________________

Any previous complications from chemotherapy or radiation? ___________________________________

When was your last treatment completed? ____

Is there a history of ovarian cancer in your family? ____