



Have you ever had a history of drug use?  YES  NO If so, please list what drugs \_\_\_\_\_

Are you currently seeing a therapist?  YES  NO If yes, who do you see? \_\_\_\_\_

Have you ever received medication for depression?  YES  NO If yes, what was it? \_\_\_\_\_

Do you have any other issues you wish to discuss?  YES  NO Please list here \_\_\_\_\_

### **Hospitalizations**

*Please list date and nature of hospitalization below.*

#### **Operations**

#### **Hospitalization for illness or injury**

1) \_\_\_\_\_ 1) \_\_\_\_\_

2) \_\_\_\_\_ 2) \_\_\_\_\_

3) \_\_\_\_\_ 3) \_\_\_\_\_

Do you have any chronic or serious illnesses?  YES  NO

If yes, please list \_\_\_\_\_

### **General Physical Condition or Problems**

*Do you have any problems with any of the following? If yes, please list below.*

Hearing, Eyes, Ears, Nose, Throat  YES  NO Hepatitis or any kind of liver ailment or jaundice  YES  NO

Heart problems or high blood pressure  YES  NO Kidney or bladder problems/leaking of urine  YES  NO

Lung problems/Asthma/Bronchitis  YES  NO Anemia/blood disorder/transfusion  YES  NO

Breast lumps/pain/nipple discharge  YES  NO Thyroid problems/diabetes/other endocrine problems  YES  NO

Stomach/bowel/gall bladder problems  YES  NO Headaches/migraines/nervous disorder  YES  NO

Varicose veins or phlebitis  YES  NO Chicken Pox  YES  NO

Other \_\_\_\_\_

### **Family History**

*Who in your family have any of the following?*

High Blood Pressure  YES  NO \_\_\_\_\_ Breast Cancer or Breast Disease  YES  NO \_\_\_\_\_

Stroke  YES  NO \_\_\_\_\_ Colorectal cancer  YES  NO \_\_\_\_\_

Heart Problems  YES  NO \_\_\_\_\_ Ovarian cancer  YES  NO \_\_\_\_\_

Kidney Problems  YES  NO \_\_\_\_\_ Hepatitis/TB/or any other infectious disease  YES  NO \_\_\_\_\_

Diabetes  YES  NO \_\_\_\_\_ Other \_\_\_\_\_

### **Genetic History**

*Please complete if you are pregnant or contemplating pregnancy in the future.*

Do you know of any family history of genetic disorders or birth defects?  YES  NO

Do you know of any family history of the following abnormalities? If yes, please tell us the relationship.

Sickle Cell Anemia  YES  NO Fragile X  YES  NO Hemophilia  YES  NO

Thalassemia  YES  NO Cystic Fibrosis  YES  NO Spinal Bifida  YES  NO

Tay-Sachs Disease  YES  NO Huntington's Chorea  YES  NO Cleft Lip/Palate  YES  NO

Down's Syndrome  YES  NO Muscular Dystrophy  YES  NO Chromosomal problem  YES  NO

Is there any family history of developmental delay?  YES  NO

Please list any concerns you may have regarding pregnancy or future pregnancy \_\_\_\_\_

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