UNIVERSITY PRIMARY CARE

Please list past hospitalizations and/or surgeries

_____

_____

Family History

Living Age (or age at death) List serious illnesses

Mother _____

Father _____

Sisters _____

Brothers _____

Illness — Which family member?

Anemia / Blood disease _____

Cancer _____

Diabetes _____

Glaucoma _____

Heart disease _____

High blood pressure _____

HIV disease / AIDS _____

Mental illness / depression _____

Stroke _____

Other serious illness _____

Females – Gynecological History

How many times have you been pregnant? _____ Date of last Pap smear ____/____/____

Have you had an abnormal Pap smear? ☐ Yes ☐ No Results _____

Have you had a sexually transmitted disease? ☐ Yes ☐ No Diagnosis _____

Date of last mammogram ____/____/____ Results _____

Have you ever had a breast biopsy? ☐ Yes ☐ No Results _____

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.

Patient / Legal Guardian signature _____ **Date** ____/____/____

Physician signature _____ **Date** ____/____/____