FAMIILY HISTORY:

Family History	Age if Living	Age at Death
Father		
Mother		
Brothers: Number_______		
Sisters: Number _______		
Children: Boys _______		
Girls _______		

IMUNIZATIONS & DATES			
MMR			
Polio			
Pertussis			
Tetanus			
Hepatitis B			

(Write Yes, No, or DK (don't know), for blood relatives):

___Alcoholism
___Allergies
___Anemia
___Arthritis
___Asthma
___Cancer
___Colitis
___Diabetes
___Drug Addiction
___Gastrointesinal disorders
___Gout
___Hay fever
___Heart disorders
___High blood pressure
___Hypoglycemia
___Liver disorders
___Mental illness
___Migraine
___Seizures
___Skin disorders
___Stroke
___Thyroid disorders
___Tuberculosis
___Venereal disease

Other significant family health problems? ____
____

DO YOU HAVE A LIVING WILL? (This could include, but is not limited too, an Advance Medical Directive, Durable Power of Attorney, or Health Care Proxy.) ☐ **Yes** ☐ **No** If yes, and Dr. Dumovic is your Primary Care Physician, we are required by law to have a copy on file.

OTHER COMMENTS- Any additional information you feel would be helpful for Dr. Dumovic to know.
____
____

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FEMALES ONLY: Please Complete

Menstrual cycles : Regular? ☐ **Yes** ☐ **No** **Length of cycle?** ____________________

Hysterectomy? ☐ **No** ☐ **Yes Total?** ________________ **Partial?** ____________________

Number of Pregnancies?______ **Births?** ______ **Miscarriages?** _______ **Abortions?** _______

History of Breast lumps? ☐ **Yes** ☐ **No** **Do you use birth control pills?** ☐**Yes** ☐ **No**

Check if you have had: _____**D & C** _____ **Toxemia** ____ **Cesarean Section**
_____**Difficulty with pregnancy** _____ **with Labor** _____ **with Delivery**

Date of last Pap? ________________ **Date of last Mammogram?** ________________