Connor's Healthcare for Women

PLEASE FILL OUT THE FOLLOWING:

NAME: _____

ALLERGIES: _____

DO YOU SMOKE? ____ YES _____ NO
DO YOU DRINK ALCOHOL? _____ YES _____ NO

PAST MEDICAL HISTORY: _____
_____
_____
_____

CURRENT MEDICATIONS: _____
_____
_____
_____
_____

PAST SURGERIES: _____
_____
_____
_____

FAMILY MEDICAL HISTORY: Hypertension, Diabetes, ETC
PLEASE LIST: _____
_____
_____
_____

FAMILY HISTORY OF:
BREAST CANCER _____ YES _____ NO
COLON CANCER _____ YES _____ NO

PHARMACY THAT YOU USE: _____