

**WOMEN'S HEALTH CENTER OF LEBANON, LTD.
PERSONAL HISTORY FORM**

Name: _____ DOB: _____ Date: _____

Address: _____ Phone # () _____

Occupation: _____ Company Name: _____ Phone # () _____ ext. _____

Can we call you at work: Yes No if yes when: _____

Marital Status: _____ Emergency contact: _____

Husband Name: _____ Occupation: _____ Company Name _____

Social Security # _____ Primary Care Physician: _____

1. Social History:

Tobacco: Yes No How Much: _____

Alcohol: Yes No How Much: _____

Caffeine: Yes No How Much: _____

2. List all Medications:

| | Name | Dosage |
|----|-------|--------|
| 1. | _____ | _____ |
| 2. | _____ | _____ |
| 3. | _____ | _____ |
| 4. | _____ | _____ |
| 5. | _____ | _____ |

3. List all Allergies to Medications:

1. _____
2. _____
3. _____

4. List all Surgeries:

1. Type: _____ Dates: _____
2. Type: _____ Dates: _____
3. Type: _____ Dates: _____
4. Type: _____ Dates: _____
5. Type: _____ Dates: _____

5. List all Medical Problems you have:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

6. Family History:

1. **Breast Cancer:** Yes No Who: Mother Sister Aunt Other: _____
Age of Diagnosis: _____
2. **Ovarian Cancer:** Yes No Who: Mother Sister Aunt Other: _____
3. **Uterine Cancer:** Yes No Who: Mother Sister Aunt Other: _____
4. **Colon Cancer:** Yes No Who: Father Mother Sister Brother Other: _____
5. **Diabetes:** Yes No Who: Father Mother Brother Sister Uncle Aunt Other: _____
6. **Hypertension:** Yes No Who: Father Mother Brother Sister Uncle Aunt Other: _____
7. **Heart Disease:** Yes No Who: Father Mother Brother Sister Uncle Aunt Other: _____
8. **Other:** _____

