Tufts Medical Center

Women's Care South at Tufts Medical Center
15 Braintree Hill Office Park, Suite 201, Braintree, MA 02184
Telephone: 781-843-2229 Fax: 781-848-2227

Date: _____

Name: _____ Birth Date: _____

FAMILY HISTORY

Please list any member of your family (blood relative) who had:

1. Cancer (list type) _____
2. Hypertension (high blood pressure) _____
3. Heart Disease _____
4. Diabetes _____
5. Stroke _____
6. Drug or Alcohol Addiction _____
7. Bleeding Disorder _____
8. Any other condition that runs in your family _____

_____

SOCIAL HISTORY

Do you live alone? ☐ Yes ☐ No; If no, who lives with you? _____

Do you work outside the house? ☐ Yes ☐ No; If yes, type of work? _____

Are you under unusual stress at home or work? ☐ Yes ☐ No

Do you drive? ☐ Yes ☐ No

Do you have transportation ☐ Yes ☐ No

Do you have any problem with eating or food? ☐ Yes ☐ No

Is any member of your household seriously ill? ☐ Yes ☐ No

PREVENTATIVE HEALTH

Do you smoke? ☐ Yes ☐ No; If yes, _____ packs per day for _____ years

Do you drink alcohol? ☐ Yes ☐ No; If yes, number of drinks per week? _____

Do you exercise regularly? ☐ Yes ☐ No; If yes, type of exercise? _____

Are you trying to lose or gain weight? ☐ Yes ☐ No; If yes, how? _____

Do you wear seatbelts? ☐ Yes ☐ No

Do you wear a bike helmet? ☐ Yes ☐ No

Have you ever felt you ought to cut down on your drinking? ☐ Yes ☐ No

Do you do breast self-exams? ☐ Yes ☐ No

Have you worked with chemicals, paints, asbestos or hazardous material? ☐ Yes ☐ No

Have you ever been physically hurt (kicked, bruised, hit) by your partner? ☐ Yes ☐ No

Are you afraid of your partner or anyone else? ☐ Yes ☐ No

Are you planning a pregnancy in the near future? ☐ Yes ☐ No

Does your partner use drugs or alcohol? ☐ Yes ☐ No

(please turn over and complete opposite side)

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Date: _____

Name: _____ Birth Date: _____

FAMILY HISTORY

(continued from front of sheet)

When was your last:

Pap Smear _____

Mammogram _____

Cholesterol _____

Stool Check for Blood _____

Pelvic Exam _____

Breast Exam _____

HIV Test _____

Have you ever used:

☐ Sleeping Pills

☐ Any IV Street Drugs

☐ Tranquilizers

☐ LSD, Hallucinogens

☐ Diet Pills

☐ Valium

☐ "Speed" or "Uppers"

☐ Cocaine

☐ Marijuana

☐ Heroin

☐ Non-Medical Steroids

Do you donate blood? . . . . . ☐ Yes ☐ No; If yes, last donation? _____ Blood Type: _____

Have you filed a living will or health care proxy statement? . . . . . ☐ Yes ☐ No

If yes, where is it filed? _____ Who is your proxy? _____

Do you have an organ donor card? . . . . . ☐ Yes ☐ No

MEDALERT bracelet? . . . . . ☐ Yes ☐ No

Any other information you would like the doctor to be aware of:

_____

_____

_____

_____

_____

_____