

## Medical Update

Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Bra Size \_\_\_\_\_ LMP \_\_\_\_\_

Home# ( ) \_\_\_\_\_ Cell# ( ) \_\_\_\_\_ Work# ( ) \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Please list any illness, surgeries or hospitalizations in the past two years: \_\_\_\_\_

Family history of Breast Cancer: Yes \_\_\_\_\_ No \_\_\_\_\_

Self \_\_\_\_\_ Grandmother \_\_\_\_\_ Mother \_\_\_\_\_ Sister \_\_\_\_\_ Aunt \_\_\_\_\_ Daughter \_\_\_\_\_

Do you have any medical problems? (Please circle)

High Blood Pressure      Arthritis      Bleeding Disorder      Asthma

Heart Condition      Diabetes      Mitral Valve      Thyrid

Others: \_\_\_\_\_

Please list any medications you are taking:

Medication	Dosage	Times Daily	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(Any additional medications may be written on the back of this form)

Please circle if you are taking any of the following over the counter medications:

Herbs      Vitamins / Supplements      Weight loss meds      Aspirin / Anti-inflammatory

Please list any allergies you have: \_\_\_\_\_

\_\_\_\_\_