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: ____

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