

Family History

Have any of your relatives suffered from the following? (circle)
Heart Disease/ Lungs/ Kidney/ Bleeding Disease/ Cancer/ Diabetes/ Epilepsy

Females

Last menstrual period? _____ Length of cycle _____ days. Are
Number of pregnancies? _____ Ages of Children _____
Use of contraceptives? _____

*To the best of my knowledge, I am not now pregnant. I agree to advise this clinic
before my surgery date. (_____)*
initials

Is there any other information that was not covered that we should be aware of?

Patient Signature

Alfred C. Speirs

I certify there has been no change in my health history.

Signature Date

Signature Date

Signature Date

Signature Date

Signature Date

Signature Date

