The Echenberg Institute
for pelvic & sexual pain

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PAST MEDICAL AND FAMILY HISTORY FORM

Patient Name: _____ Date: _____

DOB: _____

PLEASE CHECK IF YOU OR ANY BLOOD RELATIVE HAD ANY OF THE FOLLOWING: (please specify who)

1. Weight Loss/Gain	_____Self	_____Family _____
2. Headaches/Migraines	_____Self	_____Family _____
3. Heart/Valvular Disease	_____Self	_____Family _____
4. Rheumatic Disorder	_____Self	_____Family _____
5. High Blood Pressure	_____Self	_____Family _____
6. Respiratory Disease	_____Self	_____Family _____
7. Pulmonary (Lung) Disease	_____Self	_____Family _____
8. Breast Disease	_____Self	_____Family _____
9. Jaundice/Hepatitis	_____Self	_____Family _____
10. Hiatal Hernia (Reflux)	_____Self	_____Family _____
11. Peptic Ulcer (Stomach)	_____Self	_____Family _____
12. Bowel Disease	_____Self	_____Family _____
13. Kidney Disease	_____Self	_____Family _____
14. Urinary Insentience	_____Self	_____Family _____
15. Urinary Infections	_____Self	_____Family _____
16. Blood Transfusions	_____Self	_____Family _____
17. Anemia/Blood Disorder	_____Self	_____Family _____
18. Varicose Veins/Phlebitis	_____Self	_____Family _____
19. Skin Disease	_____Self	_____Family _____
20. Diabetes	_____Self	_____Family _____
21. Thyroid Disease	_____Self	_____Family _____
22. Cancer (type)_____	_____Self	_____Family _____
23. Epilepsy/Neurologic Disorder	_____Self	_____Family _____
24. Arthritis/Joint Pain	_____Self	_____Family _____
25. Osteoporosis/Fragile Bones	_____Self	_____Family _____
26. Anxiety/Depression	_____Self	_____Family _____
27. Sleep Problems	_____Self	_____Family _____
28. Other:		

Please Explain:

_____

_____

_____