ANKE OTT YOUNG, M.D.

Medical History Update

Patient Name: _____ Patient ID: _____

Height: _____ Weight: _____ BMI: _____

Bra Size: _____

Do you get regular periods? Circle One: YES NO Are you Menopausal? Circle One: YES NO

Date Last Mammogram: _____ Name of facility: _____

Has there been a change in medications since your last visit? Circle One: YES NO If yes, please list medications currently taking. Please include herbal remedies and over the counter medications

	Name of Medication	Dosage	Frequency
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Do you have or have had any of the following conditions?

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Arthritis			Asthma			Bleeding problems		
Breast Cancer RT LT			Bone Cancer			Lung Cancer		
Colon Cancer			Other Cancer: _____			Diabetes		
Depression / Anxiety			High Cholesterol			Hypertension		
Thyroid Disease			Heart Disease			Kidney Disease		
Liver Disease			Stroke			Hernia		
Other: Please Explain								

Have there been any additional surgeries since your last visit?

Surgery	Date	Problems with Anesthesia /Complications