NAME _____ DATE OF BIRTH _____ DATE _____

PAST MEDICAL HISTORY (Check Here if **NO** to All _____)

Anxiety Disorder	Y / N	Hypertension	Y / N
Asthma	Y / N	Kidney Disease	Y / N
COPD	Y / N	Liver Disease	Y / N
Cancer GI	Y / N	Pulmonary Embolism	Y / N
Coronary Artery Disease	Y / N	Radiation	Y / N
Depression	Y / N	Sleep Apnea	Y / N
Diabetes	Y / N	Stroke	Y / N
Diverticulitis	Y / N	TIA	Y / N
Fibromyalgia	Y / N	Thyroid Disease	Y / N
GERD/Reflux	Y / N	Valvular Heart Disease	Y / N
HPV Vaccine	Y / N	Other _____	
High Cholesterol	Y / N	_____	

SOCIAL HISTORY

Advance Directive	Y / N				
Alcohol Intake	None _____	Occasional _____	Moderate _____	Heavy _____	
Alcohol Years of Use	_____ year(s)				
Smoking Status	Former _____	Current _____			
How Much	1 PPW _____	2 PPW _____	¼ PPD _____	½ PPD _____	
	1 PPD _____	1½ PPD _____	2 PPD _____	3+PPD _____	
Years of Smoking	_____ year(s)	At what age did you begin smoking? _____			
Illicit Drugs	Y / N				

FAMILY HISTORY

Mother - Alive Y / N Cause if deceased _____
Father - Alive Y / N Cause if deceased _____
Does anyone or has anyone in your family had:

Colon Cancer	Y / N	Relation to you _____
Colon Polyps	Y / N	Relation to you _____
Colitis	Y / N	Relation to you _____
Crohn's Disease	Y / N	Relation to you _____
Family History of Cancer	Y / N	Relation to you _____
Other _____		Relation to you _____

YOUR PHYSICIANS (Who should receive a report/letter)

Primary Care _____
GI (If you have a doctor) _____
Hematology/Oncology _____
Gynecology _____
Urology/Gynecology _____
Any Other Physician _____