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 ____