Personal History

Please list all medications you are taking (over the counter and prescription)

Please list any allergies you have (medications, foods, pets, seasonal, other)

Please list any chronic conditions you have (asthma, diabetes, glaucoma, high blood pressure, other)

Please list all major illness, injuries, surgeries, and/or hospitalizations within the last 10 years

Family History

Has a blood relative ever had	Y	N
Anemia		
Arthritis		
Diabetes		
Glaucoma		
Heart Disease		
High Blood Pressure		
High Cholesterol		
Thyroid Disease		

Please see Cancer History Form attached

Social History

	Y	N	If yes, how often?
Tobacco			
Alcohol			
Recreational Drugs			

Preventative Screenings

In the past year, have you had?	Y	N
Blood Pressure Check		
Blood Test		
Flu Shot		
Physical Exam		

Men Only

In the past 2 years, have you had?	Y	N
Colonoscopy		
Prostate Exam		
Testicular Exam		

Women Only

In the past 2 years, have you had?	Y	N
Colonoscopy		
Mammogram		
Pap Smear		