Name: ____ DOB: _______________

Reason for today's visit: ____

☐ **NO KNOWN DRUG ALLERGIES**

Please list all allergies(food/medication/tape/latex)**:**

Allergen	Reaction

Check any medical problems you may have:

☐	Abdominal Pain	☐	Colonic Diverticulosis	☐	Heart Attack ________year	☐	Mass ________location
☐	Acid Reflux/Heartburn	☐	Congestive Heart Failure	☐	Heart Disease	☐	Melanoma-Skin
☐	AIDS	☐	COPD	☐	Hemorrhoids	☐	MRSA
☐	Anemia	☐	Coronary Heart Disease	☐	Hepatitis A/B/C	☐	Neuropathy
☐	Anxiety	☐	Crohn/Ulc.Colitis	☐	Hernia_______________	☐	Pacemaker
☐	Arthritis	☐	Cyst _________location	☐	High Blood Pressure	☐	Prostate Cancer
☐	Asthma	☐	Defibrillator	☐	High Cholesterol	☐	Rectal Bleeding
☐	Basal Cell Carcinoma	☐	Depression	☐	HIV	☐	Seizures
☐	Blood Clot	☐	Diabetes/type_____________	☐	Irregular Heart Beat	☐	Shortness of Breath
☐	Breast Cancer	☐	Dialysis	☐	Irritable Bowel Syndrome	☐	Skin Cancer
☐	Breast Lump/Cyst/Lesion	☐	Diverticulitis of Colon	☐	Kidney Problems	☐	Sleep Apnea
☐	Breast Pain/Discharge	☐	Fatty Liver	☐	Kidney Stone	☐	Squamous Cell Carcinoma
☐	Cancer _________________	☐	Gallstones	☐	Lesion ________location	☐	Stroke/TIA
☐	Cirrhosis	☐	GERD	☐	Liver Disease	☐	TB
☐	Colon Cancer	☐	Goiter	☐	Lymphoma	☐	Thyroid Problems

Other____

____

Social History:

Tobacco Use	Alcohol Use	Recreational Drug Use
☐ Never	☐ Never	☐ Never
☐ Former/year quit________	☐ Current _____drinks per day	☐ Current
☐ Current ____packs per day	☐ Former/year quit________	☐ Former/year quit________
Cigarettes Smokeless tobacco	Wine Beer Liquor	

Past Surgical History: ☐ **NO SURGERY HISTORY**

Procedure	Date	Surgeon

Family History **(Please check all the following that apply):** ☐ **UNKOWN/ADOPTED**

	Mother	Father	Sister	Brother	Father's Family	Mother's Family
Asthma						
Breast Cancer						
Colon Cancer						
COPD (Emphysema)						
Crohn's Disease						
Diabetes						
Epilepsy						
Heart Attack						
Heart Failure						
High Blood Pressure						
Kidney Disease						
OtherCancer_______						
Stroke						
Thyroid						
Deceased						

Other____

Current Medications: ☐ **NO CURRENT MEDICATIONS**

Medication	Dose	Times Taken per Day

Women Only

Is there a possibility you could be pregnant? Yes No

Number of pregnancies: ___________ Full Term: ___________ Miscarriages: _________ C-Section: Yes No

Age of first period: ________ Age of menopause: ________