Patient Name:

Please list any medical problems including any well controlled problems such as hypertension or diabetes:

Please list all medications you are currently taking:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

Please list the names of any specialists you are seeing and what you see them for (i.e. Dr. Doe for hypertension, etc.)

Specialist's Name	**Diagnosis**

Have you ever had any surgeries? Please list them: ____________________________

Is your father still alive? Yes/No If he is deceased, at what age did he die?___________
What medical problems did/does your father have? _____________________________
Is your mother still alive? Yes/No If she is deceased, at what age did she die?________
What medical problems did/does your mother have? ____________________________

Have you ever been a smoker? Yes/No
Are you still a smoker? Yes/No For how many years? ______
If you are a former smoker, when did you quit? ______ How long did you smoke?___________
Do you Vape or chew nicotine containing products? Yes/No
Are you single? married? divorced? widowed?
If you are still working, what company do you work for?__________________________
What do you do for a living?____
How much alcohol do you drink in a week? ____________________________________
Do you use any recreational drugs? Yes/No If yes, what recreational drugs do you use?

When was your last pap smear done?_______________________

<u>If you are over 50:</u>
When was your last colonoscopy?_________
Who was the doctor that performed this?________ When are you due again?________
When was your last Mammogram? _______________