

1. Are you experiencing any symptoms not on Medical History list? \_\_\_ Yes \_\_\_ No

2. and if yes, what are they?

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3. What past surgical procedures have you had?

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4. Social History

Do you presently smoke? \_\_\_\_\_ Packs a day \_\_\_\_\_ # of years \_\_\_\_\_

If you don't smoke now, have you ever smoked? \_\_\_\_\_

How much and how long did you smoke? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ If so, how much \_\_\_\_\_

Do you have a history of illegal drug use? \_\_\_\_\_

5. Allergies

Are you allergic to any medication, dye, or food? Please list and your reactions.

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6. Family History

Have any of your blood relatives (father, mother, siblings, aunts, uncles) had the following:

\_\_\_\_\_ Heart Problems \_\_\_\_\_ Strokes \_\_\_\_\_ Stomach/Colon problems

\_\_\_\_\_ High Blood Pressure \_\_\_\_\_ Diabetes

\_\_\_\_\_ Cancer If Cancer, what kind? \_\_\_\_\_

7. Advanced Directives

A. Living Will \_\_\_\_\_ B. Durable Power of Attorney for Healthcare \_\_\_\_\_

I do not have Advance Directives \_\_\_\_\_

For Staff Use:

Patient

Signature: \_\_\_\_\_ Date: \_\_\_\_\_