

TODAYS DATE: _____

NAME: _____ DATE OF BIRTH: _____

PRIMARY CARE DOCTOR: _____

REFERRING DOCTOR: _____

REASON FOR VISIT: _____

MEDICAL HISTORY:

<i>Medical Problem</i>	<i>Year Diagnosed</i>	<i>Physician</i>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

SURGICAL HISTORY:

<i>Operation or Hospitalization</i>	<i>Year</i>	<i>Hospital</i>	<i>Physician</i>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____

CURRENT MEDICATIONS:

<i>Name</i>	<i>Dosage</i>
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

ALLERGIES:

1. _____
2. _____
3. _____
4. _____

HEIGHT: _____ ft _____ in

WEIGHT: _____ 1bs

DO YOU SMOKE? YES NO

IF YES HOW MUCH: _____

DO YOU DRINK ALCOHOL?

IF YES HOW MUCH: _____

OCCUPATION: _____

FAMILY HISTORY OF CANCER:

WHO: _____ TYPE: _____

WHO: _____ TYPE: _____