Medical record # _____

Patient Name:_____**Date:**_____

Patient Height: _____ft. _____in. **Weight:** _____lbs. BMI (office use only): _____

Medical/Surgical History

Have there been any changes, within the past year, to your medical/surgical history? Yes No

If yes, please state: _____

_____

_____

Medications

Do you take any medications (prescription, over the counter, herbal remedies or vitamins)? Yes No

If yes, please list names as well as dosage :_____

_____

_____

_____

Do you take a blood thinner (incl. Aspirin)? Yes No If yes, please specify: _____

Allergies

Do you have any allergies to medication, environment or food? Yes No

If yes, please list along with reaction: _____

_____

Social History

Are you a current smoker? ---------- Yes No If yes, how many_____pack(s) per day

Are you a former smoker? ----------Yes No If yes, when did you stop? _____

When was your last flu shot? date_____ never____ unable____

Have you had a colonoscopy? Yes No If yes, when? _____

***For Women Only*:**
Have you had a mammogram? Yes No If yes, when? _____