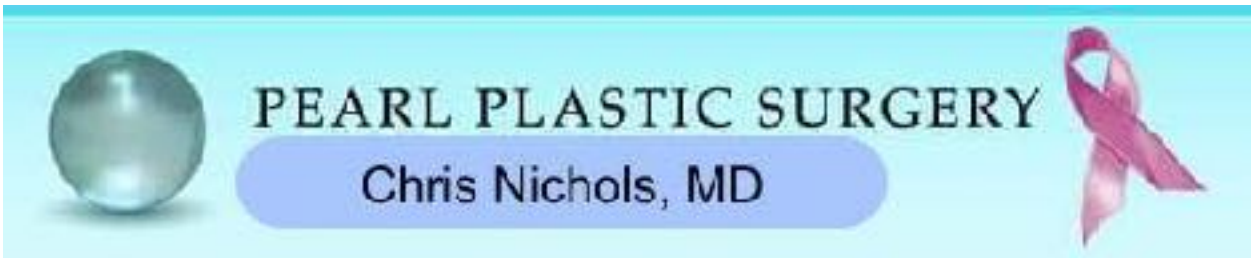


Name_____

Health History

Your doctor will be able to provide better care for you if he/she is completely familiar with your medical history. Please take a few moments and answer the following questions as thoroughly as possible. The doctor will review the answers with you in more detail during your exam. ***Please also be sure to bring, or provide us, a current list of your medications prior to your appointment***. Thank you.

Describe current and past use of alcohol, tobacco, and exercise

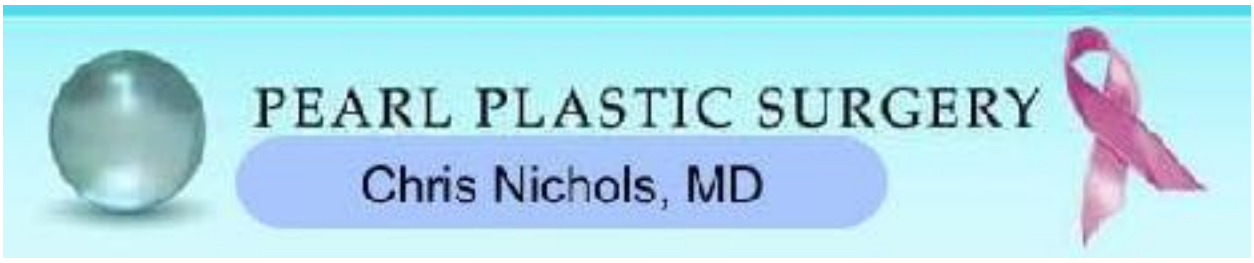
Smoking	**Chewing Tobacco**	**Alcohol Use (circle)**	**Marital Status (circle)**
Pack(s) per day:_____ # Years Smoking:_____ What year did you Quit?:_____	None/Never ◯ 1/day ◯ 2-4/day ◯ 5+/day ◯	Never ◯ Occasional ◯ Moderate ◯ Heavy ◯	Single ◯ Married ◯ Separated ◯ Widowed ◯ Domestic Partner ◯ Other ◯

Please answer **Yes** or **No** to each of the following questions.

Is there any family/personal history of excessive bleeding or blood clotting?	Yes/ ◯ No ◉
Is there any family/ personal history of a bad reaction to general anesthetic?	Yes/ ◯ No ◉
Family/personal history of cancer? If yes please list *relationship* and *cancer type/ location* (See below)	Yes/No ◯ ◉

FAMILY MEMBER *(EXAMPLE*: Maternal Aunt)	TYPE OF CANCER (EXAMPLE: *breast cancer)*	

List all allergies (including medications, tape, latex, etc...)



ALLERGY (EXAMPLE: Latex)	REACTION TO ALLERGY (EXAMPLE: breathing trouble)

Please list all operations you have had with the location of surgery and approximate date:

Operation	Location (hospital and city)	Approximate date

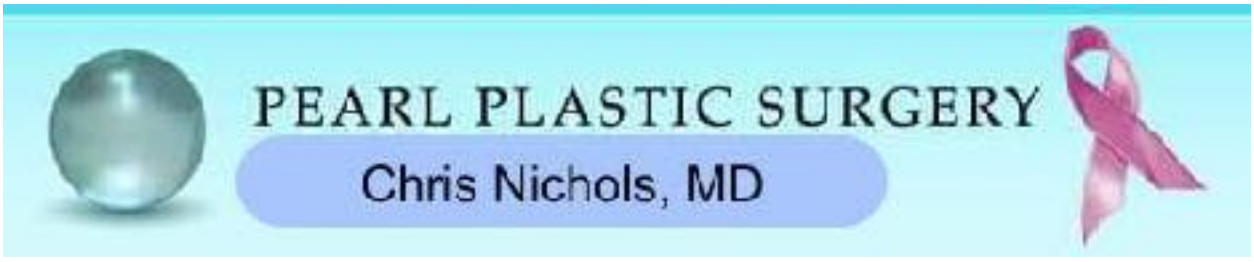
PLEASE SEE THE ATTACHED PAGE TO LIST YOUR MEDICATIONS OR PROVIDE A CURRENT LIST OF YOUR MEDICATIONS

MEDICATION LIST

Please be sure to include any supplements or vitamins taken on a regular basis.

Name:_____

Signature_____Date_____



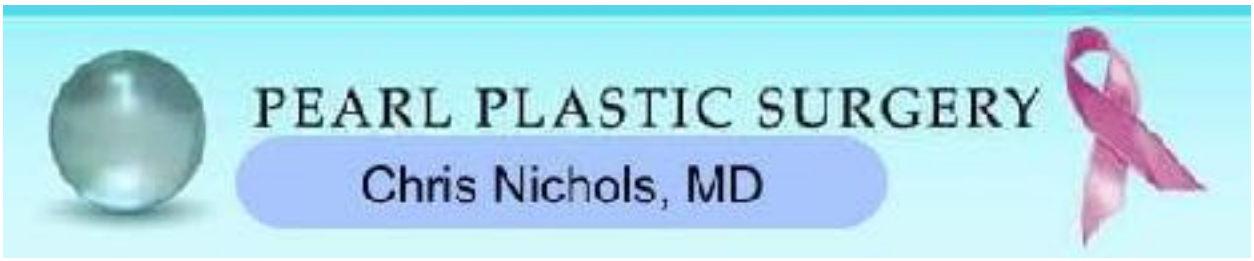
Circle any medical problems that other doctors have diagnosed or that you currently take medication for.

☐ High Blood Pressure	☐ Kidney Disease	☐ Open Wounds
☐ Heart Condition	☐ Diabetes	☐ Thyroid Condition
☐ Cancer	☐ egular Heart Rhythm	☐ Chronic Infections
☐ Stroke/TIA	☐ Asthma	☐ Herpes/Pox/Shingles
☐ Neurological Problems	☐ Chronic Pain	☐ Lung Conditions
☐ Tuberculosis/ Positive TB Test	☐ Lupus/Scleroderma	Other

Any other current/past diagnosed health conditions

_____

_____



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Name_____

Signature_____Date_____