

Current Medications:

Name	Dosage	Reason for Medication
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do You Use Tobacco Products? _____ **If So, How Often?** _____

Do You Drink Alcohol? _____ **If So, How Often?** _____

Family Medical History (please check if anyone in your family has ever had any of the following conditions):

Colon Cancer	_____	Colon Polyps	_____	Colitis	_____
Crohn's Disease	_____	Heart Disease	_____	Stroke	_____
Excessive Bleeding	_____	Diabetes	_____	Hypertension	_____
High Cholesterol	_____				
Complications from Anesthesia	_____				

If you checked any of these, please give family relationship: _____

Date of Last Physical: _____

Date of Last Prostate Evaluation (if applicable): _____

Date of Last Pap Smear (if applicable): _____ **Mammogram** (if applicable): _____

Please List Any Additional Relevant Medical Issues: _____

