Surgical History: please list all previous surgeries and dates, if possible:
_____
_____
_____

Family History (parents, grandparents, siblings, etc): please circle all that apply:
-None
-Cancer, what kind: _____
-Heart Disease: _____
Diabetes: _____
Other: _____

You're Occupation (now or before retirement)
_____

Recreational Activities: _____

Have you ever used tobacco? Yes / No

Cigarettes: How many packs per day? _____ How long _____ quit _____

Cigars/Pipes

Chew Tobacco/Snuff

Do you drink alcohol? Yes / No

Number of drinks per week: _____

Current Medications: _____
_____
_____

Drug Allergies: _____

For female patients only:
-date of last mammogram: _____ Results: _____
Last menstrual period: _____ Are you pregnant: _____
Number of pregnancies: _____Number of live births: _____
C-Section: Yes / No did you breast feed: Yes / No

I herby certify that all the information is accurate and correct.

Signature_____ Date: _____