PAST MEDICAL HISTORY

Patient Name:_____ Date:_____

SOCIAL HISTORY:

HOW MUCH PER DAY DO YOU USE THE FOLLOWING?

Tobacco_____ Alcohol_____ Coffee/Tea _____

If you ever used tobacco: Number of years? Packs per day? Quit When?

DIETS:

ARE YOU ON ANY SPECIAL DIETS?_____

Your FAMILY HISTORY:

HAVE ANY OF **YOUR BLOOD RELATIVES** EVER HAD ANY OF THE FOLLOWING?

_____Bladder Cancer _____Tuberculosis _____Stroke _____Gout

_____Prostate Cancer _____Heart Disease _____Bleeding Disorder _____Diabetes

_____Testicular Cancer _____Heart Attack _____High Blood Pressure

_____Other Cancer (Describe):_____

ALLERGIES:

LIST ALL **DRUG ALLERGIES:** _____NONE ?

_____

_____

LIST ALL **HOSPITALIZATIONS** AND **SURGERIES**:

(include childhood hospitalizations and surgeries)

_____Date: _____

_____Date: _____

_____Date: _____

_____Date: _____

_____Date: _____

LIST ANY OTHER **MEDICAL ILLNESSES** (and how long you have had them):

Illness:_____How long? _____

Illness:_____How long? _____

Illness:_____How long? _____

HAVE YOU EVER BEEN DIAGNOSED AS HAVING CANCER? YES NO

If yes, what type?_____

# Answer	Level of service
0	1 or 2
1 – 2	3
3	4 or 5

Initial	Date