Name:_____ Date: _____

Life Style:	Yes	No	Past
Tobacco			
Alcohol			
Recreational Drugs			
Exercise			

Occupation: _____

Preventive Care	Date	Result
Colonoscopy		
Bone Density		
Mammogram		
Pap-smear		
Flu Vaccine		
Pneumonia Vaccine (Over 65)		
Tetanus Booster		
Shingles Vaccine (Over 60)		

Surgical History:

_____

_____

Medication Allergies: _____

_____

Any other concerns/problems: _____

_____

I have completed the above to the best of my knowledge.

_____ _____

Patient Signature **Date**