Chronic Health Concerns / Past Medical History

Surgeries

Medications & Supplements / Dose	

Allergies / Intolerance	

Family History	Illness
Mother	
Father	
Brother (s)	
Sister (s)	
Colon Cancer? (circle any that apply)	Mother Father Brother Sister

Substance Use	Please Circle One
Tobacco	None Quit Present How long _____ How much_____
Alcohol	None Quit Present How long _____ How much_____
Recreational Drug Use	None What have you used?
	Marijuana Intravenous Intranasal