Name

Chronic Health Concerns/Past Medical History

Last Colonoscopy

Surgeries

Medications Reviewed Date

Allergies

Family History	Illness
Mother	
Father	
Brother(s)	
Sister(s)	

Family history of Colon Cancer ? (circle any that apply) **Mother** **Father** **Sister** **Brother**

(Nondiscriminatory, For Medical Information Only)

Tobacco Have you ever smoked? No Yes,Start Date? Still Smoking? No, Quit Date Yes, How many packs a day?

Alcohol Have you ever Drank? No Yes,Start Date? Still Drinking? No, Quit Date Yes, How many Drinks per week?

Recreational Drug Use No Yes What have you used? Marijuana Intranasal Intravenous Other