

LESLEY J. ANDERSON M.D.
ROBERT J. PURCHASE M.D.

- **MEDICATIONS:** please list the medications you are currently using (use other side if needed):

- **ALLERGIES TO MEDICATIONS:** _____

<p><u>RISK FACTORS</u></p> <input type="checkbox"/> Current, daily smoker <input type="checkbox"/> Current, sometime smoker <input type="checkbox"/> Smoker, status unknown <input type="checkbox"/> Never smoker <input type="checkbox"/> Former smoker <input type="checkbox"/> Unknown if ever smoked	<p><u>RACE CHOICES</u></p> <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> White <input type="checkbox"/> Unknown	<p><u>ETHNICITY CHOICES</u></p> <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown
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Do you drink alcohol daily? Y / N	Do you exercise daily? Y / N	Do you drink caffeine? Y / N
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- **GENERAL HEALTH:** please mark if you have a history of any of the following:

<input type="checkbox"/> High blood pressure	<input type="checkbox"/> HIV	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Sinus disease
<input type="checkbox"/> Heart attack/Angina	<input type="checkbox"/> Cancer	<input type="checkbox"/> Prior severe injury	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Neuro problem	<input type="checkbox"/> Wt. loss/fevers
<input type="checkbox"/> Bleeding problem	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Anesthesia problems	<input type="checkbox"/> Hx of sexual abuse
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke	<input type="checkbox"/> Lung disease	<input type="checkbox"/> Check if pregnant

Other serious illnesses: _____

- **PRIOR SURGERY:** _____

- **FAMILY HISTORY:** do you have a family history of:

<input type="checkbox"/> Heart disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> High cholesterol
<input type="checkbox"/> Colon cancer	<input type="checkbox"/> Breast cancer	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Stroke

Detail: _____

Signature

Date