

Name			Occupation			
In your own words describe what brings you to the doctor:			Height		Weight	
			Allergies to Medications			
Please list all medical problems you have had in the past:			Please list all operations you have had in the past:			
			Operation		Date	
Please list all medications you currently take:			Do you have any of the following symptoms:		Yes	No
			Weight loss			
			Vision problems			
			Ear pain			
			Nose bleeds			
			Cough			
	Yes	No	Chest Pain			
Do you smoke or have you ever smoked regularly						
Do you drink alcohol regularly						
Do you have a family history of cancer			Depression			
			Leg weakness			