

Are you taking any herbal, over-the-counter or alternative/complementary medications, vitamins or supplements? If so, list them below:

Agent	Dose	How often?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any allergies to medications? If yes, list them below:

Medication	What happens when you take it?
_____	_____
_____	_____
_____	_____

Social History

Do you smoke? Yes No
If yes, how much per day? _____ For how long? _____
If you used to smoke, how much per day? _____ For how long? _____
When did you quit? _____

Do you drink alcohol? Yes No
If yes, how much and how often? _____

Family History

Has anyone in your family been diagnosed with any new cancer condition(s) since your last office visit?
If so, list them below:

Review of Systems

Do you have any of the following?

- Easy bruising or bleeding
- Headaches
- Fatigue
- Loss of appetite
- Weight loss
- Chest pain
- Shortness of breath
- Nausea/vomiting
- Abdominal pain
- Skin rashes or changes
- New bone or joint pain(s)

Please explain any above checked boxes _____

