Name (Last, First, M.I.)

Date of Birth (Month, Day, Year)

If you have completed sections 41 since your last birthday, please proceed to section that apply.

```
1. Medical History
 $QHPLD
                   '&+)+HFÐilUlreW
                                     ' +HDUW 'LVHDVH ' 6HL]XUHV
                  ' 'HŚUHVVLRQ
                                     ' +,9 $,'6
                                                        ' 6WURNH
 $Q[LHW\
' $UWKULWLV
                  ' 'LDEHWHV
                                     ' +\SHUWHQVLRQ ' 7K\URLG 3UREOF
 $VWKPD ' (PSK\VHPD &23' Pressure %OHHGLQJ'LVRI' *(5' +HDUWEXUQ' .LGQH\'LVHDVH' 2WKHU BBBBBB
 $VWKPD
' % O R R G & O R W V ' Reflux
                                       /LYHU 'LVHDVH
                                      '3DOSLWDWLRQV_
'&DQFHU
2. Surgical History
                   '&RURQDU\$UWH'+HUQLD5HSDLU'2UJTDaQosplant
' 1R 6XUJHU\
                                     Location:
'$QHVWKHVLD &R'&RURQDU\$UWH'+LS 5HSODFHPH+'2WKHU BBBBBBB
 $SSHQGHFWRP\ '(\H 6XUJHU\
                                      ' +\VWHUHFWRP\
' %UHDVW 6XUJHU
                                       .QHH 5HSODFHPI_
' &RORQRVFRS\
                   ' *DOOEODGGHU 6 ' 3URVWDWH 6XUJ
                                     '6SLQH6XUJHU\
                  (Cholecystectomy)
3. Social History
                                                        Sexually Active
Alcohol Use
                                     TobaccoUse
                  Street Drug Use
' < H V ' 1 R
            '1HYI'<HV '1R '1HYI'<HV '1R '1HYI'<HV '1R '1RW
' Wine
                    0 D U L M X D Q D
                                     Type __
                                                        Partners (check all that apply)
'%HHU
                    OHWKDPSKHWDP '&XUUHQW 6PRNF')HPDOH 'ODOH
'/LTXRU
                    & R F D L Q H
                                                        Birth Control/Protection
                                     Packs per day _____
                    +HURLQ
                                                         ' < H V ' 1 R
                   '2WKHU
                                      ')RUPHU 6PRNHU Method
```

4. Family Medical History

Name (Last, First, M.I.)	Health History  Questionnaire	
Date of Birth (Month, Day, Year)		
Primary Care Network     A. Allergies to Medications/Latex-Please indicate	type of reaction	
B. Medications: Please list current medications. you take the medication.	Include herbal &tbeerounter me	dications, dose & how many times a day

<u>Medication</u>	<u>Dose</u>	How many times perday