Name: ______________________________ Date:__________________

Date of Birth: ___________________________

HEALTH CONSULT

1. Do you have high blood pressure? YES ❑ NO ❑
2. Has it been over one year since you last completed blood tests? YES ❑ NO ❑
3. Has it been over one year since your last visit to an eye doctor? YES ❑ NO ❑
4. When was your last colonoscopy? _____________ Was it normal? YES ❑ NO ❑
5. Is there any family history of any cancer? If yes, type, age and relation?_______________
6. Colon Cancer? YES ❑ NO ❑ If yes, age and relation? __________________________
7. What is your current exercise plan? ____
8. Tobacco or alcohol use? How much, since what age? ______________________________

MEN

Family history of Prostate (or other male specific) cancer? YES ❑ NO ❑

If yes, age and relation?____

WOMEN

1. Date of last pap smear______________Was it normal? YES ❑ NO ❑

2. Date of last mammogram_____________Was it normal? YES ❑ NO ❑

3. Family history of breast, cervical, ovarian or uterine cancer? YES ❑ NO ❑

If yes, age and relation?____

Please provide a copy of the most recent above stated reports along with your Immunization record.