LESLEY J. ANDERSON M.D.
SARA L. EDWARDS M.D.

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

- **ALLERGIES TO MEDICATIONS**: _____

_____

RISK FACTORS	**RACE CHOICES**	**ETHNICITY CHOICES**
☐ Current, daily smoker	☐ American Indian	☐ Hispanic
☐ Current, sometime smoker	☐ Asian	☐ Non-Hispanic
☐ Smoker, status unknown	☐ Black	☐ Unknown
☐ Never smoker	☐ Native Hawaiian	
☐ Former smoker	☐ White	
☐ Unknown if ever smoked	☐ Unknown	

Do you drink alcohol daily? Y / N	Do you exercise daily? Y / N	Do you drink caffeine? Y / N

- **GENERAL HEALTH:** please mark if you have a history of any of the following:

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

Other serious illnesses: _____

_____

- **PRIOR SURGERY:** _____

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

☐ Heart disease	☐ Diabetes	☐ High blood pressure	☐ High cholesterol
☐ Colon cancer	☐ Breast cancer	☐ Osteoporosis	☐ Stroke

Detail: _____

_____ _____

Signature Date