

## BRIEF HISTORY

Last Name:	First:	Age:	DOB:	LMP:
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<b>PAST MEDICAL HISTORY:</b>	<input type="checkbox"/> NONE
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Date	Chronic Problems	Investigations	Date	Chronic Problems	Investigations

<b>OPERATIONS:</b>	<input type="checkbox"/> NONE
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Year	Name Of Operation	Complications

<b>FAMILY HISTORY:</b>	Deceased	<input type="checkbox"/> NONE
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Father ▲	Mother ▲	Sister/Brother ▲	Grandparents ▲

<b>ALLERGIES</b>	<input type="checkbox"/> NONE
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Name of Drug	Reaction	Name of Drug	Reaction

<b>SOCIAL INFORMATION:</b>
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Do you now use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever used tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever used alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No What do you do for a living? _____ Last Pap Smear? _____ Last Colonoscopy _____ Last Mammogram _____ Last Tetanus? _____ Last Pneumovax _____ Last TB _____ Comments: _____	How much and for how many years? _____ / _____ When did you quit? _____ How much and How Often? _____ / _____ When did you quit? _____
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