



Medical History Form

Name: _____

Today's Date: _____

Date of Birth: _____

Primary Care Doctor: _____

This section is to be completed by office staff.

INFORMATION IS DOCUMENTED ON VISIT SOURCE

Blood Pressure: _____ Pulse: _____ Height: _____ Weight: _____

Family History	
Does any 1 st degree relative have cardiac disease?	<input type="checkbox"/> No <input type="checkbox"/> Yes, describe:
Does any 1 st degree relative have an autoimmune disorder?	<input type="checkbox"/> No <input type="checkbox"/> Yes, describe:
Does any 1 st degree relative have memory impairment?	<input type="checkbox"/> No <input type="checkbox"/> Yes, describe:
Does any 1 st degree relative have a history of cancer?	<input type="checkbox"/> No <input type="checkbox"/> Yes, describe:

Allergies			
Any drug allergies? <input type="checkbox"/> No <input type="checkbox"/> Yes, type: <input type="checkbox"/> No <input type="checkbox"/> Yes, type: <input type="checkbox"/> No <input type="checkbox"/> Yes, type:	Start:	End:	<input type="checkbox"/> Ongoing
	Start:	End:	<input type="checkbox"/> Ongoing
	Start:	End:	<input type="checkbox"/> Ongoing
Any non-drug allergies? <input type="checkbox"/> No <input type="checkbox"/> Yes, type: <input type="checkbox"/> No <input type="checkbox"/> Yes, type: <input type="checkbox"/> No <input type="checkbox"/> Yes, type:	Start:	End:	<input type="checkbox"/> Ongoing
	Start:	End:	<input type="checkbox"/> Ongoing
	Start:	End:	<input type="checkbox"/> Ongoing
Any previous vaccine reactions? <input type="checkbox"/> No <input type="checkbox"/> Yes, type: <input type="checkbox"/> No <input type="checkbox"/> Yes, type: <input type="checkbox"/> No <input type="checkbox"/> Yes, type:	Start:	End:	<input type="checkbox"/> Ongoing
	Start:	End:	<input type="checkbox"/> Ongoing
	Start:	End:	<input type="checkbox"/> Ongoing



Patient's Initials _____

Disease / Syndrome	Yes	No	Start Date (YEAR)	Resolved Date (YEAR)	Procedure/Surgery (include date performed)	Clinically Significant (for EDC)*
Gastrointestinal System (Check box if ongoing)						
Acid Reflux	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Colon Polyps	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Colonoscopy (most recent)	<input type="checkbox"/>	<input type="checkbox"/>		N/A		<input type="checkbox"/> Yes
Constipation	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Diverticulosis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Dyspepsia	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Dysphagia	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Gallstones	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Gastroparesis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
GERD	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Indigestion	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Irritable Bowel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Pancreatitis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Ulcer	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Ulcerative Colitis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Other:				<input type="checkbox"/>		<input type="checkbox"/> Yes



Disease / Syndrome	Yes	No	Start Date (YEAR)	Resolved Date (YEAR)	Procedure/Surgery (include date performed)	Clinically Significant (for EDC)*
Hepatic / Liver (Check box if ongoing)						
Alpha-1 Antitrypsin Deficiency	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Fatty Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Hemochromatosis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Other:				<input type="checkbox"/>		<input type="checkbox"/> Yes
Genitourinary (Check box if ongoing)						
Endometriosis <input type="checkbox"/> N/A	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Fibroids <input type="checkbox"/> N/A	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Enlarged Prostate <input type="checkbox"/> N/A	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Erectile Dysfunction <input type="checkbox"/> N/A	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Low Libido / Sex Drive	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Menopause	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Urination Problems <input type="checkbox"/> Difficulty Starting <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Urinary Incontinence	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes



Disease / Syndrome	Yes	No	Start Date (YEAR)	Resolved Date (YEAR)	Procedure/Surgery (include date performed)	Clinically Significant (for EDC)*
Genitourinary Continued (Check box if ongoing)						
Urinary Tract Infection	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Other:				<input type="checkbox"/>		<input type="checkbox"/> Yes
Hematological (Check box if ongoing)						
Anemia	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Vitamin B12 Deficiency	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Vitamin D Deficiency	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Other:				<input type="checkbox"/>		<input type="checkbox"/> Yes
Eyes, Ears, Nose, & Throat: (Check box if ongoing)						
Cataracts: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Dry Eye	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Farsighted	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Nearsighted	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Presbyopia	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Retinopathy	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Other:				<input type="checkbox"/>		<input type="checkbox"/> Yes



Disease / Syndrome	Yes	No	Start Date (YEAR)	Resolved Date (YEAR)	Procedure/Surgery (include date performed)	Clinically Significant (for EDC)*
Neurological (Check box if ongoing)						
Carpal Tunnel Syndrome <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Headaches	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Memory Loss: <input type="checkbox"/> Dementia <input type="checkbox"/> Alzheimer's <input type="checkbox"/> Age Related	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Migraines	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Mini-Stroke (TIA)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Sciatica	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Seizures	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Stroke	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Tremors	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Vertigo	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Other:				<input type="checkbox"/>		<input type="checkbox"/> Yes
Respiratory (Check box if ongoing)						
Asthma	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
COPD	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
COVID-19	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes



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Respiratory Continued (Check box if ongoing)						
Supplemental Oxygen Use	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Seasonal Allergies	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	CPAP Compliant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes
Other:				<input type="checkbox"/>		<input type="checkbox"/> Yes
Dermatology (Check box if ongoing)						
Acne	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Eczema	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Fungus: Location:	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Rashes	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Rosacea	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Skin Cancer (Basal)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Skin Cancer (Melanoma)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Skin Cancer (Squamous)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Other:				<input type="checkbox"/>		<input type="checkbox"/> Yes
Musculoskeletal (Check box if ongoing)						
Arthritis: Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Arthritis: Psoriatic	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Arthritis: Rheumatoid	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Back Pain	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes



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Musculoskeletal Continued (Check box if ongoing)						
Bone Injuries	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Gout	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Muscle Spasms	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Osteopenia	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Other:				<input type="checkbox"/>		<input type="checkbox"/> Yes
Endocrine / Metabolic (Check box if ongoing)						
Diabetes Type 1	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Diabetes Type 2	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Diabetic Neuropathy	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
High Triglycerides	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Hyperthyroidism	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Hypothyroidism	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Overweight	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Other:				<input type="checkbox"/>		<input type="checkbox"/> Yes
Neoplasia (Check box if ongoing)						
Cancer:	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Other:	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes



Patient's Initials

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Cardiovascular (Check box if ongoing)						
A-Fib	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Carotid Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Coronary Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Heart Catheter	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Irregular Heart Beats	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Peripheral Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Peripheral Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Poor Circulation in Legs	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Statin Intolerant	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Stent	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Swelling in Legs or Feet <input type="checkbox"/> Right Foot <input type="checkbox"/> Left Foot <input type="checkbox"/> Right Leg <input type="checkbox"/> Left Leg <input type="checkbox"/> Chronic <u>or</u> <input type="checkbox"/> Intermittent	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Other:				<input type="checkbox"/>		<input type="checkbox"/> Yes



Disease / Syndrome	Yes	No	Start Date (YEAR)	Resolved Date (YEAR)	Procedure/Surgery (include date performed)	Clinically Significant (for EDC)*
Infectious Disease (Check box if ongoing)						
C. Diff	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
HIV	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Other:				<input type="checkbox"/>		<input type="checkbox"/> Yes
Autoimmune Disease (Check box if ongoing)						
Celiac Disease	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Lupus	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Sjogren's Syndrome	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Other:				<input type="checkbox"/>		<input type="checkbox"/> Yes
Psychiatric (Check box if ongoing)						
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Attention Deficit Disorder (ADD)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Attention Deficit Hyperactivity Disorder (ADHD)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Depression	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/> Yes
Other:				<input type="checkbox"/>		<input type="checkbox"/> Yes



Vaccination History					
COVID-19 (Most Recent) Date: N/A		Type:	Prior COVID-19 Vaccinations? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/>
Flu (Most Recent) Date:			<input type="checkbox"/> N/A	Tetanus (if in past 12 months) Date:	
			<input type="checkbox"/> N/A	<input type="checkbox"/> N/A	
Shingles Dose 1:		Dose 2:	<input type="checkbox"/> N/A	Pneumonia Dose 1:	
			<input type="checkbox"/> N/A	Dose 2:	
			<input type="checkbox"/> N/A	<input type="checkbox"/> N/A	

Personal Habits	
Do you have a history of tobacco use? <input type="checkbox"/> Current <input type="checkbox"/> Former <input type="checkbox"/> Never	Type (If applicable): <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars <input type="checkbox"/> Smokeless <input type="checkbox"/> Pipe <input type="checkbox"/> Vape
Smoking Start Date: _____ Amount Smoked/Day: _____ Smoking End Date: _____	
Do you have a history of recreational drug use? <input type="checkbox"/> Current <input type="checkbox"/> Current, with prescription <input type="checkbox"/> Former <input type="checkbox"/> Never	
Do you have a history of alcohol abuse? <input type="checkbox"/> Current <input type="checkbox"/> Former, length of sobriety: _____ <input type="checkbox"/> Never	
On average, how many alcoholic drinks do you consume weekly?	

For Women Only	
Can you still have children? <input type="checkbox"/> Yes, list birth control _____ <input type="checkbox"/> No, reason: <input type="checkbox"/> Post-menopausal <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Ovaries removed	
Last Mammogram:	Last Well-Woman Exam:

Patient Signature: _____ Date: _____

Study Coordinator Signature: _____ Date: _____

Clinically Significant for EDC <input type="checkbox"/> N/A



*Only use this column on medical history for protocols that specify clinically significant medical history for data entry.

Investigator Signature of Clinical Significance[#] Review, if required:

Signature:

Date:

[#]Items marked "YES" in the clinically significant column should be entered into EDC based on investigator judgment and protocol-specific requirements.