NAME _____ DATE OF BIRTH _____ DATE OF APPOINTMENT _____

How many caffeinated drinks do you have each day? (circle one) 0 1 2 3 4+

When was your last colonoscopy? _____ Where _____

When was your last flu shot? _____ Where _____

When was your last pneumovax? _____ Where _____

Do you *CURRENTLY* use tobacco? YES NO If yes do you use ___ cigarettes or _____ chewing tobacco

In the past year how many times have you consumed more than 5 alcoholic beverages in 1 day? _____ times

Female patients only - Have you experienced urinary incontinence within the last 12 months? YES NO

REVIEW OF SYSTEMS

Do you currently have any problems related to the following system?

Circle answer for each.

CARDIOVASCULAR

Chest Pain	Y	N
Irregular Pulse	Y	N
Swelling of Ankles	Y	N
Severe Headache	Y	N
Chest Discomfort to Arm	Y	N

GASTROINTESTINAL

Abdominal Pain Black	Y	N
Stools	Y	N
Heartburn/Vomiting	Y	N
Constipation	Y	N

UROLOGIC

Blood in Urine	Y	N
Blood in Ejaculate	Y	N
Burning	Y	N
Wetting with cough/sneeze	Y	N