



**Allergies**     \_\_\_ I have no known allergies

Please list below	Reactions

<b>Surgical History</b>	<b>Surgery</b>	<b>Year</b>

<b>Medical History</b>	<b>You</b>	<b>Family Member</b>	<b>Relationship</b>
No history of disease			
Asthma			
Diabetes			
Heart Disease			
Hypertension			
Kidney Stone			
Stroke			
Breast Cancer			
Bladder Cancer			
Kidney Cancer			
Prostate Cancer			
Other Cancer			
Hemophilia			

<b>Other History</b>	<b>None</b>	<b>Yes</b>	<b>How Much</b>
Tobacco Use			
Alcohol			
Caffeine			
Drug Use			