Patient Name:_______________________________________ Birth Date: _________________

CURRENT MEDICATIONS

Drug Name	Dosage	Times Per Day	Drug Name	Dosage	Times Per Day

DRUG ALLERGIES

____

Have you ever smoked? NO YES If yes, how much?__________ packs per day for ___________years

Do you still smoke? NO YES

Do you now drink alcohol, or did you drink alcohol in the past? NO YES If yes, how much?____________

FAMILY HISTORY

Has any member of your family had: Colon Cancer?__________ If yes, what is his/her relationship to you?_______________

Colon Polyps?__________ If yes, what is his/her relationship to you?_______________

Inflammatory Bowel Disease
(Crohn's, Ulcerative Colitis)?_________ If yes, what is relationship to you?_______________

	Alive	Current Age	Decesaed	Age at Death	Significant Medical Problems / Cause of Death
Mother					
Father					
Sister(s)					
Brother(s)					

Do you have a living will or durable power of attorney? NO YES (If yes, please provide a copy for our records.)