LEASE LIST ILLNESSES (for which you see a Doctor or take medication)

_____

_____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

FAMILY HISTORY :
(Please indicate if any relative has, or had)

	AGE	RELATIONSHIP
_____**Hypertension**	_____	_____
_____**Diabetes**	_____	_____
_____**Thyroid**	_____	_____
_____**Heart Attack**	_____	_____
_____**Stroke**	_____	_____

FAMILY HISTORY OF CANCER :
(Please indicate if any relative has, or had)

	AGE	RELATIONSHIP
_____**Breast Cancer**	_____	_____
_____**Colon Cancer**	_____	_____
_____**Ovarian Cancer**	_____	_____

Please specify any other history of Cancer____

_____

SOCIAL HISTORY :

What is your Occupation?_____Retired_____Disabled_____

Do you Smoke?_____NO_____YES How many packs a day_____How many years?____

Do you Drink?_____NO_____YES____Beer_____Alcohol_____Drinks per Day

Do you Drink Coffee?_____NO_____YES____Cups per day

Have you ever any street drugs such as cocaine, marijuana, etc?___NO__YES please describe:

_____

Patient Signature:_____Date:_____

AMRITA
CLINIC
Centre For Laparoscopic Surgery

Thank you for providing complete information