Jeffrey P. Snow, M.D., P.A.
General & Colon and Rectal Surgery

Date: ______________________________ DOB: _____________________

Last Name: ____________________________ **First Name**: ______________________ **M.I.**_____

Reason for visit: ____

Medical problems:____
____
____

Past Surgery:
Surgery name with date (year): ____
____
____

Medications/vitamins/over the counter daily: ____
____
____
____
____

Drug Allergies: ____
____
____

Tobacco Use:
Did you ever smoke cigarettes YES____ NO_____ (If no, please skip to Alcohol use)
Current Every Day Smoker? Yes____NO___ Current some day smoker? Yes___ NO____
Former Smoker? Yes___ NO___ When did you quit?______ # of years smoking_____
Smoke Socially Yes___ NO_____Smokeless tobacco use? YES___ NO___

Alcohol Use:
Do you drink alcohol? YES___ NO____ If yes, how much?_____________________
Never Drinks alcohol? YES___ NO____ Quit drinking alcohol Yes___ NO If yes, when?__________

Vaccinations:
Influenza immunization? YES__ NO__ If yes, When (Month & Year) _____________
Pneumonia vaccination? YES__ NO__ If yes, When (Month & Year) _____________

COLONOSCOPY: ________________(within the past 3years) please provide date
PAP SMEAR: ____________________ (within the past 3years) please provide date

MAMMOGRAM: (DATE)____________ **WHERE:**___________________
RESULTS OF MAMMO:____

Please check the spaces below that pertains to you. Have you recently experienced:

Constitutional __weight changes, __ fever, __fatigue __None of these

Eyes __ visual changes, __ pain __None of these

Ears, Nose & Throat __sore throat, __sinus trouble, __ nose bleeds __None of these

Cardiovascular __chest pain, __ palpitations, __ leg cramps __ None of these

Respiratory __ cough, __shortness of breath, __ wheezing __ None of these

Gastrointestinal __abdominal pain, __constipation, __ bloody or dark stools __None of these

Genitourinary__pain with urination, __ frequent urination at night __None of these

Musculoskeletal __arthritis, __limitation of movement __None of these

Skin __rash, __lumps, __bruises __None of these

Neurological __fainting, __headaches, __numbness __None of these

Psychiatric __depression, __ panic attacks __None of these

Endocrine __thyroid problems, __ hot flashes __None of these

Hematological __ bleeding problems, __ anemia __ None of these

Allergy/Immunology __ Steroid use, __hives, __ HIV __ None of these

PLEASE CIRCLE ONE IF YOU ARE A NEW PATIENT TO THE PRACTICE. IF NOT, PLEASE IGNORE:

Race (circle one): Alaskan Native, American Indian, Asian, African American, Hispanic or Latino, Indian, Native Hawaiian, Caucasian, White Hispanic, Refuse to report

Ethnicity (circle one): Hispanic or Latino, Non Hispanic or Latino, Refuse to Report

OFFICE USE ONLY (PLEASE DO NOT COMPLETE BELOW LINE)

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Patient Weight:______________ Patient Height:_______________Blood Pressure: _______/_______ (R/L)

Primary Care Physician:_________________________

Referring Physician:____________________________

OBGYN:_____________________________________

Other Physicians:_______________________________

Doctor Reviewed Document

Physician Signature:____