

COLON RECTAL HEALTH CENTER

DR. STEVE M. ABBADESSA

HUMAN PAPILLOMA VIRUS

Please Print:

Last Name: _____ First: _____ MI: _____

Have you had warts in the past? Yes No If yes, Genital Anal

Have you had treatment on the warts? Yes No

If yes, what type of treatment? Excision

Acid

Cream

Other

How long have the warts been visible? _____ Days _____ Weeks _____ Months _____ Years

Are you HIV positive? No Yes Not sure

If yes, are you currently being treated? No Yes, If yes, Please explain: _____

Have you been tested for any other Sexual Transmitted Diseases (STD)? No Yes

If Yes, please list test and results:

_____/_____
_____/_____

List ALL other medications you are currently or have recently taken: including prescription drugs, over the counter, vitamins and minerals, herbal and/or supplements, etc:

1. _____ Dose: _____ 4. _____ Dose: _____

2. _____ Dose: _____ 5. _____ Dose: _____

3. _____ Dose: _____ 6. _____ Dose: _____

Do you have any allergies? No Not Sure Yes If yes: Food Medication(s) Latex Iodine Other

Please list all allergies and reactions:

ALLERGY	REACTION	ALLERGY	REACTION
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you smoke cigarettes? Yes No If yes, how many? _____/day Years? _____

Do you drink alcohol? Yes No If yes, how often? _____/Week _____/Month _____/Year

Are you on a special diet? Yes No If Yes, please explain: _____

Have you lost any weight in the past 6 weeks? Yes No # of lbs.? _____