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.? _____

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