Do not write, stamp, punch holes or affix a sticker in this area.

Direction of Feed

Personal / Family History

Please answer every question

To reproduce, follow the printing instructions. Do not fold this form.

Marking Instructions

Please use a # 2 pencil
Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

SOCIAL HISTORY

TOBACCO USE

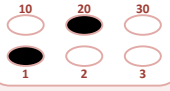
What is your smoking status? current (every day) ○ current (some days) ○ previous ○ never ○

At what age did you begin smoking?

If you quit smoking, at what age did you quit?

How many cigarettes do you currently smoke or did you previously smoke per day?

EXAMPLE
If you started smoking at the age of 21, you would fill in the ovals like this:



How many cigars or pipes do you smoke per week? 0 ○ <1 ○ 1-2 ○ 3-5 ○ 6-9 ○ 10+ ○

How many cans of smokeless / chewing tobacco do you use per week? 0 ○ <1/2 ○ 1/2 ○ 1 ○ 2 ○ 3+ ○

Are you exposed to passive (second hand) smoke? yes ○ no ○

ALCOHOL USE

How often do you use alcohol? (number of times...) never ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7+ ○ (per...) week ○ month ○ year ○

(If you marked "never", please skip to Drug Use section)

What type(s) of alcohol do you drink? beer ○ wine ○ liquor ○

How many drinks do you have per occasion? 1-2 ○ 3-5 ○ 6-9 ○ 10+ ○

How often do you have more than five drinks per occasion? never ○ occasionally ○ rarely ○ frequently ○

DRUG USE

none ○ current ○ previous ○ prefer to discuss with physician ○

HIV HIGH RISK BEHAVIOR?

(HIV Risk Factors: IV drug use, More than one sexual partner, Sex with a prostitute, Unprotected sexual contact, Contact with contaminated injection equipment.)

yes ○ no ○ prefer to discuss with physician ○

HABITS

Caffeine

-type(s) of caffeine: coffee ○ tea ○ soft drinks ○

-drink(s) per day: occasionally ○ 0 ○ 1-2 ○ 3-4 ○ 5-6 ○ 7+ ○

Exercise

-type(s) of exercise: bicycling ○ running ○ swimming ○ walking ○ aerobics ○ other ○

-time(s) per week: occasionally ○ 0 ○ 1-2 ○ 3-4 ○ 5-6 ○ 7+ ○

How often do you wear a seatbelt? always ○ almost always ○ occasionally ○ never ○

Sun Exposure: occasionally ○ frequently ○ rarely ○

YOUR MEDICAL HISTORY

Please indicate if YOU have a history of, or currently have any of the following.
(Mark all that apply. If none, mark, "NONE of the Above.")

PAST	ACTIVE	
○	○	Alcohol Abuse
○	○	Anemia
○		Anesthetic Complication
○	○	Anxiety Disorder
○	○	Arthritis
○	○	Asthma
○	○	Autoimmune Problems
○	○	Birth Defects
○	○	Bladder Problems
○	○	Blood Disorder
○	○	Blood Clots
○	○	Blood Transfusion(s)
○	○	Bowel Disease
○	○	Depression
○	○	Diabetes
○	○	Growth / Development Disorder
○	○	Heart Attack
○	○	Heart Disease
○	○	Heart Pain / Angina
○	○	Hepatitis A
○	○	Hepatitis B
○	○	Hepatitis C
○	○	High Blood Pressure
○	○	High Cholesterol
	○	HIV
○	○	Hives
○	○	Kidney Disease
○	○	Liver Disease
○	○	Respiratory Disorder
○	○	Mental Illness
○	○	Migraines
	○	Osteoporosis
○	○	Reflux / GERD
○	○	Seizures / Convulsions
○	○	Severe Allergic Reaction / Anaphylaxis
○	○	Sexually Transmitted Disease
○	○	Stroke
○	○	Suicide Attempt
○	○	Thyroid Disorder
○	○	Ulcer
	○	**NONE of the Above**

CANCER HISTORY

Please indicate if YOU have a history of, or currently have any of the following cancers.
(Mark all that apply. If none, mark, "No Cancer.")

PAST	ACTIVE	
○	○	Bladder Cancer
○	○	Breast Cancer
○	○	Cervical Cancer
○	○	Colon Cancer
○	○	Kidney Cancer
○	○	Leukemia
○	○	Liver Cancer
○	○	Lung Cancer
○	○	Melanoma
○	○	Non-Hodgkin Lymphoma
○	○	Pancreatic Cancer
○	○	Prostate Cancer
○	○	Rectal Cancer
○	○	Skin Cancer
○	○	Thyroid Cancer
○	○	Uterine Cancer
○	○	Other Cancer
○	○	**No Cancer**

FAMILY MEDICAL HISTORY

Please indicate if YOUR FAMILY has a history of the following.
(ONLY include parents, grandparents, siblings, and children.
Mark all that apply. If none, mark, "NONE.")

- ○ **FAMILY HISTORY UNKNOWN**
- ○ Alcohol Abuse
- ○ Anemia
- ○ Anesthetic Complication
- ○ Arthritis
- ○ Asthma
- ○ Bladder Problems
- ○ Blood Disorder
- ○ Breast Cancer
- ○ Colon Cancer
- ○ Depression
- ○ Diabetes
- ○ Heart Disease
- ○ High Blood Pressure
- ○ High Cholesterol
- ○ Kidney Disease
- ○ Respiratory Disorder
- ○ Migraines
- ○ Osteoporosis
- ○ Rectal Cancer
- ○ Seizures / Convulsions
- ○ Severe Allergic Reaction / Anaphylaxis
- ○ Stroke
- ○ Thyroid Disorder
- ○ Other Cancer
- ○ **NONE**