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Using Adobe Acrobat Reader 8.0 or later

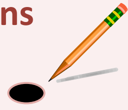
Patient History

Please answer every question.

STAFF: Responses in boxes and handwritten items must be entered **MANUALLY**.

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 ◯

How many packs per day do you (or did you) smoke? less than 1 ◯ 1-2 ◯ more than 2 ◯

How many years have you (or did you) smoke?

less than 5	5	10	15	20	25	30	35	40+
◯	◯	◯	◯	◯	◯	◯	◯	◯

Does anyone in your household smoke? yes ◯ no ◯

ALCOHOL USE

Do you consume alcohol? currently ◯ in the past ◯ never ◯

Average number of drinks per week (now or in the past)? 7 or less ◯ 8-14 ◯ 15 or more ◯

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 none ◯ occasionally ◯ frequently ◯

How many times per week do you exercise? occasionally ◯ none ◯ 1-2 ◯ 3-4 ◯ 5-6 ◯ 7+ ◯

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

Sun Exposure: occasionally ◯ frequently ◯ rarely ◯

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

PAST	ACTIVE	
◯	◯	Non-Hodgkin's Lymphoma
◯	◯	Pancreatic Cancer
◯	◯	Prostate Cancer
◯	◯	Rectal Cancer
◯	◯	Skin Cancer
◯	◯	Thyroid Cancer
◯	◯	Uterine Cancer
◯	◯	Other Cancer

◯ **No Cancer**

(U.S. Patent No. 7,487,102) (U.S. Patent No. 7,941,328)

SAMPLE

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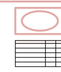
Patient History

Please answer every question.



STAFF: Responses in boxes and handwritten items must be entered **MANUALLY**.

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		PAST	ACTIVE	
◯	◯	Alcohol Abuse	◯	◯	Hepatitis A
◯	◯	Anemia	◯	◯	Hepatitis B
◯		Anesthetic Complication	◯	◯	Hepatitis C
◯	◯	Anxiety Disorder	◯	◯	High Blood Pressure
◯	◯	Arthritis	◯	◯	High Cholesterol
◯	◯	Asthma		◯	HIV
◯	◯	Atrial Fibrillation	◯	◯	Hives
◯	◯	Autoimmune Problems	◯	◯	Joint Replacement
◯	◯	Back Pain	◯	◯	Kidney Disease
◯	◯	Birth Defects	◯	◯	Liver Disease
◯	◯	Bladder Infections	◯	◯	Mental Illness
◯	◯	Blood Clot – Arm or Leg (DVT)	◯	◯	Migraines
◯	◯	Blood Clot – in Lung (PE)		◯	Osteoporosis
◯	◯	Blood Disorder	◯	◯	Reflux / GERD
◯	◯	Blood Transfusion(s)	◯	◯	Respiratory Disorder (Lung)
◯	◯	Bowel Disease	◯	◯	Seizures / Convulsions
◯	◯	Depression	◯	◯	Severe Allergic Reaction / Anaphylaxis
◯	◯	Diabetes	◯	◯	Sexually Transmitted Disease
◯	◯	Growth / Development Disorder	◯	◯	Stomach / Gastric Ulcer
◯	◯	Heart Attack	◯	◯	Stroke
◯	◯	Heart Disease	◯	◯	Suicide Attempt
◯	◯	Heart Murmur	◯	◯	Thyroid Disorder
◯	◯	Heart Pain / Angina	◯		**NONE of the Above**

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 of the Above.")

◯ **FAMILY HISTORY UNKNOWN**	◯ Depression	◯ Respiratory Disorder (Lung)
◯ Alcohol Abuse	◯ Diabetes	◯ Seizures / Convulsions
◯ Anemia	◯ Heart Disease	◯ Severe Allergic Reaction / Anaphylaxis
◯ Anesthetic Complication	◯ High Blood Pressure	◯ Stroke
◯ Arthritis	◯ High Cholesterol	◯ Suicide Attempt or Suicidal Thoughts
◯ Asthma	◯ Kidney Disease	◯ Thyroid Disorder
◯ Bladder Problems	◯ Mental Illness	◯ Tuberculosis
◯ Blood Disorder	◯ Migraines	◯ Other Cancer
◯ Breast Cancer	◯ Osteoporosis	
◯ Colon Cancer	◯ Rectal Cancer	◯ **NONE of the Above**

DOMESTIC VIOLENCE

Please answer the following 2 questions.

Have you ever been hit, slapped kicked, or hurt by someone this year?	yes ◯	no ◯
Are you afraid of your partner or anyone else close to you?	yes ◯	no ◯

PEDIATRIC SOCIAL HISTORY

Please answer the following questions.

Does your child receive dental care?			yes ◯	no ◯
Who does your child live with?	both parents ◯	mother ◯	father ◯	other ◯
Do you have smoke detectors?			yes ◯	no ◯
Does anyone smoke in the home?			yes ◯	no ◯
Do you have pets?			yes ◯	no ◯
How do you heat your home:	wood ◯	gas ◯	electric ◯	space heater ◯
Do you have help with child care?			yes ◯	no ◯
Do you have any nutritional concerns?			yes ◯	no ◯
Does your child have a car seat / booster seat?			yes ◯	no ◯
Are you concerned about any abuse in the home?			yes ◯	no ◯

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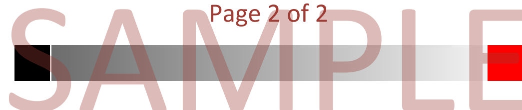

SAMPLE