MRN#	Patient Medical History Age 13 and older	STAFF: Responses in boxes and handwritten items must be entered MANUALLY.
	PLEASE PRINT PATIENT'S LAST NAME	
Marking Instructions	A STATE OF THE STA	
lease use a #2 pencil. ill in the complete oval as shown	PLEASE PRINT PATIENT'S FIRST NAME	PATIENT'S DATE OF BIRTH
		Month Day Year

Please complete this history form. This will allow us to serve your health needs. The information contained herein is strictly confidential and will not be released unless you authorize us to do so.

What is your smoking status?	current (every day)	current (some o	lays) 🔵	previous		never	
How many packs per day do you (or		less than 1		1-2	mo	re than 2	
How many years have you (or did yo	u) smoke?	less than 5	5 10	15 20	25	30 35	40+
			\circ				
Does anyone in your household smo				yes		no	
Do you use other tobacco products?		currently		in the past		never	
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	
OTHER							
Do you live alone?				yes		no	
IV drug use or other recreational dru		currently		in the past		never	
Have you engaged in high risk behav							
(anal sex, homosexual activity, multi	ple sex partners)	currently	\bigcirc	in the past		never	
Are you sexually active?				yes		no	
Have you ever had a blood transfusion	on?			yes		no	
Do you see a dentist regularly?				yes		no	
Do you have any tattoos?				yes		no	
Do you have working smoke detector				yes		no	
How often do you exercise? (times p	· · · · · · · · · · · · · · · · · · ·						
occasionally 🔘	0 1-2	3-4		5-6		7	
Do you always wear seat belts?				yes		no	
Do you have guns in your home?				yes		no	
SURGICAL HISTORY	Please mark all su	rgeries you have had.					
I HAVE HAD NO SURGERIES							
Appendectomy							
Breast Augmentation	Hysterectomy (not due to cancer)		Prostate Su	rgerv		
Breast Lumpectomy	Inguinal Hernia			Shoulder Su			
Breast Ediffication	Kidney Remova			Sinus Surge			
Carotid Artery Surgery	Kidney KemovaKnee Surgery	I.		Thyroid Rer			
Cataract Surgery	Low Back Disc S	urgρry		Tonsillector			
Colostomy	Lung Surgery	uigeiy		Total Hip Re		ment	
Foot Surgery	Mastectomy			Total Knee			
Gallbladder Surgery	Neck Disc Surge	rv		Tubal Ligati	•	Cilicit	
Heart Bypass Surgery	Ovary Removal	ı y		Vasectomy			
Hysterectomy (due to cancer)	Pacemaker			Weight Los		erv	
Trysterectomy (due to cancer)	- Tacemaker			vveignt Los.	s Juige	21 y	
Caesarean Section	1 🔾		nore 🔘				
Heart Valve Replacement	mitral 🔵	aortic 🔾 tricu	ıspid 🔵	unkn	own v	alve 🔘	
Other Surgery (please specify):							

SOCIAL HISTORY

TOBACCO USE

Print in Color or Grayscale Only

Using Adobe Acrobat Reader 8.0 or later

YOUR MEDICAL HISTORY

Patient Medical History Age 13 and older

Please indicate if **YOU** have a history of the following.

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

		Mark all tha	t apply. If	none, mar	k, " <mark>NO ME</mark> [DICAL HIST	ORY."			
PAS	T CURRENT				PA	ST CUR	RENT			
		Abnormal Pap	Smear				Hig	gh Blood Pro	essure	
		Alcohol Abuse					Hig	gh Choleste	rol	
		Allergies / Sin	us					/ /AIDS		
		Alzheimers						pothyroid (Low Thyroi	d)
		Anemia						itable Bowe	-	,
		Anxiety						lney Stones		
		Arthritis						er Cancer		
		Asthma						ng Cancer		
		Birth Defects						pus		
		Bleeding Disea	ase					elanoma (Sk	(in)	
		Blindness						graines	,	
		Blood Clots						ıltiple Scler	osis	
		Breast Cancer						teoporosis	00.0	
		Bipolar Disord						rkinson's Di	sease	
		Cataracts						ostate Canc		
		Cervical Cance	or .					ostate Prob		
		Colon Cancer	-1					raplegia	iciiis	
		Congestive He	art Failure					adraplegia		
		COPD / Emphy						flux / GERD		
		Coronary Arte						eumatic Fe		
		Crohn's Diseas						eumatoid A		
		Depression	,,,					izures / Con		
		Diabetes Type	1					xually Trans		ease
		Diabetes Type						ep Apnea	militied Dis	Lusc
		Glaucoma	_					omach Ulce	r	
		Gout						oke / CVA o		
		Hearing Loss						icide Attem		
		Heart Attack						berculosis	ρι	
		Hepatitis B) IU	berealosis		
		Hepatitis C						MEDICAL	HISTORY	
Other	Disease, Cancer	•	edical Illne	ss (please	specify):					
FAM	IILY MEDICA	L HISTORY	Please	indicate i	f <u>YOUR FAI</u>	<u>VIILY</u> has a	history of t	he followin	ng.	
			C Fai	nily Histor	y UNKNOV	VN			OPTED	
	Please indica	ate which								
	family ments have had thes		Father	Mother			Grandmother Father's side		Brother	Sister
	Ale	cohol Abuse								
		Anemia								
		Arthritis								
		Asthma								
		Bipolar								
	Bleed	ding Disease								
	Breast Cancer									
	Breast Canc	er (After 50)								
		eart Failure)								
	Colon Cancer									
		er (After 50)								

COPD / Emphysema

Diabetes Type 2 (Adult)
Diabetes Type 1

Depression

		atient Age	13 an			У								ms mu <u>LLY</u> .	ıst		
-			PLEASE P	RINT PAT	IENT'S L	AST NAM	1E								-		
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	indicate which																
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nave nac				Wioti	iei s siue	Wiother's	Siuc	rutiler :	3 SIUC	ruti	(C) 3 3	luc		_			
	High Cholesterol			(\geq)	$\overline{}$			$\stackrel{\bigcirc}{=}$			\rightleftharpoons		$\frac{\circ}{\circ}$	
	Hypertension	0		($\overline{\underline{}}$)				\bigcirc			\geq		0	
Hypothyroid	dism (Low Thyroid)	0	0	($\overline{}$)		<u> </u>		\bigcirc			\geq		0	
	Migraines		0	(\geq)		<u> </u>		$\stackrel{\bigcirc}{=}$			\geq		$\frac{\circ}{\circ}$	
	Osteoporosis	0	0		$\frac{\circ}{\circ}$)				$\frac{\circ}{\circ}$			\supseteq		0	
	Prostate Cancer										\bigcirc			\geq		$\frac{\circ}{\circ}$	
	ires / Convulsions	0	0	($\overline{\underline{}}$))		0			\supseteq		$\overline{\bigcirc}$	
Stroke /	CVA of the Brain				\mathcal{O})		\bigcirc			\mathcal{L}		\bigcirc	
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\sim	Mother, Grandmot																
	Father, Grandfathe	r, or Broth	ner deve	loped H	eart D	isease k	oetor	e the	age	of 5	5.						
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Patient Medical History Age 13 and older

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Colonoscopy					5				
Pap Smear		000			5		$\overline{}$		
Bone Density / Dexa Scan		000			5 6				
Prostate Cancer Screening		000	5		5		$\overline{}$		
ool Hemoccult (blood in stool)		000							
Eye Exam		000							
LLERGIES I HAVE NO KNOWN ALLER Latex Rubber Allergy		lease mark a	II allergi	Contra	st or lo			on Anesthe	sia
Please list any medications o (hives, rash, itching									
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