

Do not write, stamp, punch holes or affix a sticker in this area.
To reproduce, follow the printing instructions.
Do not fold this form.

Direction of Feed

Patient History

STAFF: Handwritten items must be entered **MANUALLY**.



Please answer every question

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) previous

Do you use other tobacco products?

current (some days) never

Does anyone in your household smoke?

currently in the past never

(If you have never smoked, please go to "ALCOHOL USE" section below.)

At what age did you begin smoking?

EXAMPLE

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

10	20	30
<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
1	2	3

10	20	30	40	50	60	70	80	90
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
1	2	3	4	5	6	7	8	9

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

10	20	30	40	50	60	70	80	90
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
1	2	3	4	5	6	7	8	9

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

10	20	30	40	50	60	70	80	90
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
1	2	3	4	5	6	7	8	9

ALCOHOL USE

Do you consume alcohol?

currently in the past never

If so, how much?

Number of drinks: 1 2-3 4-5 6+

Per: day week month year

OTHER

IV drug use or other recreational drug use?

currently in the past never

How often do you exercise (times per week)?

0 occasionally 1-2
3-4 5-6 7+

SURGICAL HISTORY

Please mark all surgeries you have had:

Have you ever had a Blood Transfusion?

yes no

I HAVE HAD NO SURGERIES

- Appendectomy
- Breast Augmentation
- Breast Lumpectomy
- Breast Reduction
- Carotid Artery
- Cataract
- Colon
- Foot
- Gallbladder
- Heart Bypass

- Hysterectomy (due to cancer)
- Hysterectomy (not due to cancer)
- Inguinal Hernia
- Kidney Removal
- Knee
- Low Back Disc
- Lung
- Mastectomy
- Neck Disc
- Ovary Removal
- Pacemaker
- Prostate
- Shoulder
- Sinus
- Thyroid Removal

Tonsillectomy

- Total Hip Replacement
- Total Knee Replacement
- Tubal Ligation
- Vasectomy
- Weight Loss

Cesarean Section

1 2 3 or more

Heart Valve Replacement

mitral aortic
 tricuspid unknown valve

Other Surgery (please specify):

ALLERGIES Please list all items you are allergic to:

I Have No Known **MEDICATION** Allergies

- Adhesive Tape
- Codeine
- Contrast Dye
- Eggs
- Iodine
- Latex
- Acetaminophen (Tylenol®, Excedrin®, etc.)
- NSAIDs (aspirin, ibuprofen, etc.)
- Penicillin
- Sulfa

Other Allergens (please specify):

MEDICATIONS Please list all current medications:

I Am Currently Taking **NO** Medications

(Include prescriptions, over-the-counter, vitamins, herbs and supplements.)

Name of Medication	Dosage	Frequency

SAMPLE

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

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

Direction of Feed

Patient History

Please answer every question

STAFF: Handwritten items
must be entered **MANUALLY**.



YOUR MEDICAL HISTORY

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

I HAVE NO SIGNIFICANT MEDICAL HISTORY

PAST	CURRENT		PAST	CURRENT	
<input type="radio"/>	<input type="radio"/>	Alcohol Abuse	<input type="radio"/>	<input type="radio"/>	High Blood Pressure
<input type="radio"/>	<input type="radio"/>	Allergies / Sinus	<input type="radio"/>	<input type="radio"/>	High Cholesterol
<input type="radio"/>	<input type="radio"/>	Alzheimer's Disease	<input type="radio"/>	<input type="radio"/>	HIV / AIDS
<input type="radio"/>	<input type="radio"/>	Anemia	<input type="radio"/>	<input type="radio"/>	Hypothyroid (Low Thyroid)
<input type="radio"/>	<input type="radio"/>	Anxiety	<input type="radio"/>	<input type="radio"/>	Irritable Bowel Syndrome (IBS)
<input type="radio"/>	<input type="radio"/>	Arthritis	<input type="radio"/>	<input type="radio"/>	Kidney Stones
<input type="radio"/>	<input type="radio"/>	Asthma	<input type="radio"/>	<input type="radio"/>	Liver Cancer
<input type="radio"/>	<input type="radio"/>	Bipolar Disorder	<input type="radio"/>	<input type="radio"/>	Lung Cancer
<input type="radio"/>	<input type="radio"/>	Birth Defects	<input type="radio"/>	<input type="radio"/>	Lupus
<input type="radio"/>	<input type="radio"/>	Bleeding Disease	<input type="radio"/>	<input type="radio"/>	Migraines
<input type="radio"/>	<input type="radio"/>	Blood Clots	<input type="radio"/>	<input type="radio"/>	Multiple Sclerosis (MS)
<input type="radio"/>	<input type="radio"/>	Breast Cancer	<input type="radio"/>	<input type="radio"/>	Osteoporosis
<input type="radio"/>	<input type="radio"/>	Cataracts	<input type="radio"/>	<input type="radio"/>	Parkinson's Disease
<input type="radio"/>	<input type="radio"/>	Colon Cancer	<input type="radio"/>	<input type="radio"/>	Prostate Cancer
<input type="radio"/>	<input type="radio"/>	Congestive Heart Failure	<input type="radio"/>	<input type="radio"/>	Prostate Problems
<input type="radio"/>	<input type="radio"/>	COPD / Emphysema	<input type="radio"/>	<input type="radio"/>	Reflux / GERD
<input type="radio"/>	<input type="radio"/>	Coronary Artery Disease	<input type="radio"/>	<input type="radio"/>	Rheumatic Fever
<input type="radio"/>	<input type="radio"/>	Crohn's Disease	<input type="radio"/>	<input type="radio"/>	Rheumatoid Arthritis
<input type="radio"/>	<input type="radio"/>	Depression	<input type="radio"/>	<input type="radio"/>	Seizures / Convulsions
<input type="radio"/>	<input type="radio"/>	Diabetes Type 1	<input type="radio"/>	<input type="radio"/>	Sexually Transmitted Disease (STD)
<input type="radio"/>	<input type="radio"/>	Diabetes Type 2 (adult onset)	<input type="radio"/>	<input type="radio"/>	Sleep Apnea
<input type="radio"/>	<input type="radio"/>	Gout	<input type="radio"/>	<input type="radio"/>	Stomach Ulcer
<input type="radio"/>	<input type="radio"/>	Heart Disease	<input type="radio"/>	<input type="radio"/>	Stroke / CVA of the Brain
<input type="radio"/>	<input type="radio"/>	Hepatitis B	<input type="radio"/>	<input type="radio"/>	Suicide Attempt
<input type="radio"/>	<input type="radio"/>	Hepatitis C	<input type="radio"/>	<input type="radio"/>	Tuberculosis (TB)

Other Disease, Cancer or Significant Medical Illness (please specify):

FAMILY MEDICAL HISTORY

Please indicate which family members have had these illnesses:

	Father	Mother	Brother	Sister	Son	Daughter
Alcohol Abuse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anxiety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Arthritis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Asthma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Blood Disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Breast Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Colon Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other Type of Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
COPD	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dementia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Depression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gastrointestinal Disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heart Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High Blood Pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High Cholesterol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Kidney Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Obesity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Skin Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stroke	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Thyroid Disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

FAMILY HISTORY UNKNOWN

NO SIGNIFICANT FAMILY MEDICAL HISTORY

Mother, Grandmother, or Sister
developed Heart Disease before age 65.

Father, Grandfather, or Brother
developed Heart Disease before age 55.

Other Family Medical History
(specify illness & family member):

SAMPLE