Do not write, stamp, punch holes or affix a sticker in this area. To reproduce, follow the printing instructions. Fold only on the dotted lines.

Direction of Feed

Patient History

Please answer every question

STAFF: *Responses in boxed bubbles 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

Do you have an Advance Directive or Living Will?

- I have provided an advance directive
- I have provided an advance directive at a previous visit
- I decline to provide an advance directive

Age: _____

Marital Status: single, married, partnered, separated, divorced, widowed

Occupation: _____ **Social Security Number:** _____

Home Phone #: _____ **Work Phone #:** _____

Previous Doctors you have seen: _____

please fold on dotted line

WOMEN ONLY - OB/GYN HISTORY

Age period started: n/a, under 8, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21+

Length of cycle: _____ **Date of last period:** _____

Age period stopped: n/a, under 42, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55+

Have you ever used contraceptives? currently, in the past, never

Are you pregnant or possibly pregnant? yes, no

Have you ever taken hormones? currently, in the past, never

Do you have any of the following? (Mark all that apply.)

- breast lump
- nipple discharge
- vaginal sores
- vaginal itching
- vaginal discharge
- bleeding between periods
- bleeding after intercourse
- prolonged, excessive periods

PREGNANCY HISTORY

	0	1	2	3	4	5	6	7+
Number of pregnancies:								
Number of live births:								
Number of stillbirths:								
Number of premature births:								
Number of miscarriages:								
Number of abortions:								
Number of C-sections:								

please fold on dotted line

ALLERGIES

Please mark all allergies that you have:

Medication Allergies

- **No Known MEDICATION Allergies**
- Amoxicillin
- Morphine
- Codeine
- Demerol
- Erythromycin
- Lortab
- Cephalosporins
- Oxycodone
- Penicillin
- Sulfa
- Tetracycline
- Tylenol
- NSAIDs (aspirin, ibuprofen, etc.)

Food Allergies

- **No Known FOOD Allergies**
- Eggs
- Fish
- Seafood
- Milk
- MSG
- Peanuts
- Nuts
- Soy
- Wheat
- Gluten

Environmental Allergies

- **No Known ENVIRONMENTAL Allergies**
- Bee Stings
- Dust Mites
- Animal Dander
- Adhesive Tape
- Iodine
- Mold
- Pollen
- Latex
- Seasonal Allergies (Ragweed)

OTHER (please specify): _____

Patient name: _____

Direction of Feed

Patient History

Please answer every question

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

Have YOU or a FAMILY MEMBER had any of the following:

- I Have NO CURRENT Medical Problems
- I Have NO PAST Medical Problems
- **Adopted** (Family History Unknown)
- I Have NO FAMILY Medical History

YOU			FAMILY MEMBER						
CURRENTLY	IN THE PAST		Father	Mother	Brother	Sister	Son	Daughter	
○	○		○	○	○	○	○	○	Anesthetic Complications
○	○		○	○	○	○	○	○	High Blood Pressure (Hypertension)
○	○		○	○	○	○	○	○	Diabetes
○	○		○	○	○	○	○	○	Chest Pain (Angina Pectoris)
○	○		○	○	○	○	○	○	Heart Attack
○	○		○	○	○	○	○	○	Irregular Heartbeat
○	○		○	○	○	○	○	○	High Cholesterol
○	○		○	○	○	○	○	○	Blood Clots
○	○		○	○	○	○	○	○	Anemia (Low Blood Count)

please fold on dotted line

○	○		○	○	○	○	○	○	Stroke
○	○		○	○	○	○	○	○	Emphysema / COPD
○	○		○	○	○	○	○	○	Asthma
○	○		○	○	○	○	○	○	Lung Nodules
○	○		○	○	○	○	○	○	Hepatitis B
○	○		○	○	○	○	○	○	Hepatitis C
○	○		○	○	○	○	○	○	Thyroid Nodules
○	○		○	○	○	○	○	○	Underactive Thyroid (Hypothyroidism)
○	○		○	○	○	○	○	○	Overactive Thyroid (Hyperthyroidism)
○	○		○	○	○	○	○	○	Osteoarthritis
○	○		○	○	○	○	○	○	Kidney Stones
○	○		○	○	○	○	○	○	Ulcers (Bleeding)
○	○		○	○	○	○	○	○	Cataracts
○	○		○	○	○	○	○	○	Glaucoma
○	○		○	○	○	○	○	○	Positive Tuberculosis (TB) Skin Test
○	○		○	○	○	○	○	○	Anxiety
○	○		○	○	○	○	○	○	Bipolar
○	○		○	○	○	○	○	○	Schizophrenia
○	○		○	○	○	○	○	○	Depression
○	○		○	○	○	○	○	○	ADD
○	○		○	○	○	○	○	○	Colon Polyps

please fold on dotted line

○	○		○	○	○	○	○	○	Colon Cancer
○	○		○	○	○	○	○	○	Bladder Cancer
○	○		○	○	○	○	○	○	Skin Cancer
○	○		○	○	○	○	○	○	Breast Cancer
○	○		○	○	○	○	○	○	Lung Cancer
○	○		○	○	○	○	○	○	Pancreatic Cancer
○	○		○	○	○	○	○	○	Liver Cancer
○	○		○	○	○	○	○	○	Lymphoma (Lymph Cancer)
○	○		○	○	○	○	○	○	Leukemia
○	○		○	○	○	○	○	○	Thyroid Cancer
○	○		○		○		○		Prostate Cancer
○	○			○		○		○	Cervical Cancer
○	○			○		○		○	Ovarian Cancer
○	○			○		○		○	Uterine Cancer
○	○		○	○	○	○	○	○	Bone Cancer

Patient name: _____

Direction of Feed

Patient History

Please answer every question

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

SURGICAL HISTORY

Please indicate when you have had any surgeries:

○ I Have Had NO SURGERIES

	1 year ago or less	2 years ago	3 years ago	4 years ago	5 years ago	6 years ago	7 years ago	8 years ago	9 years ago	10 or more years ago
Appendix Removed	○	○	○	○	○	○	○	○	○	○
Tonsils Removed	○	○	○	○	○	○	○	○	○	○
Gallbladder Removed	○	○	○	○	○	○	○	○	○	○
Hysterectomy (Uterus Removed)	○	○	○	○	○	○	○	○	○	○
Heart Bypass Surgery	○	○	○	○	○	○	○	○	○	○
Hemorrhoids Removed	○	○	○	○	○	○	○	○	○	○
Ovaries Removed	○	○	○	○	○	○	○	○	○	○
Spleen Removed	○	○	○	○	○	○	○	○	○	○
Colostomy	○	○	○	○	○	○	○	○	○	○
Pacemaker	○	○	○	○	○	○	○	○	○	○
Defibrillator	○	○	○	○	○	○	○	○	○	○
please fold on dotted line										
Coronary Artery Stent	○	○	○	○	○	○	○	○	○	○
Cataract (left eye)	○	○	○	○	○	○	○	○	○	○
Cataract (right eye)	○	○	○	○	○	○	○	○	○	○
Cataract (both eyes)	○	○	○	○	○	○	○	○	○	○
Partial Colon Removal	○	○	○	○	○	○	○	○	○	○
Total Colon Removal	○	○	○	○	○	○	○	○	○	○
Mastectomy (left breast)	○	○	○	○	○	○	○	○	○	○
Mastectomy (right breast)	○	○	○	○	○	○	○	○	○	○
Mastectomy (both breasts)	○	○	○	○	○	○	○	○	○	○
Hernia Repair (abdominal)	○	○	○	○	○	○	○	○	○	○
Hernia Repair (belly button / umbilical)	○	○	○	○	○	○	○	○	○	○
Hernia Repair (incisional)	○	○	○	○	○	○	○	○	○	○
Inguinal Groin Hernia Repair (left side)	○	○	○	○	○	○	○	○	○	○
Inguinal Groin Hernia Repair (right side)	○	○	○	○	○	○	○	○	○	○
Inguinal Groin Hernia Repair (both sides)	○	○	○	○	○	○	○	○	○	○

OTHER (please specify surgery and date): _____

HOSPITALIZATIONS

Please list any past hospitalizations:

_____

_____ *please fold on dotted line* _____

_____

IMMUNIZATIONS

Have you had these immunizations within the past year?

Flu ○ yes ○ no **Pneumonia** ○ yes ○ no

HEALTH MAINTENANCE PLAN

Please indicate when you last had each of the following applicable tests:

	1 year ago or less	2 years ago	3 years ago	4 years ago	5 years ago	6 years ago	7 years ago	8 years ago	9 years ago	10 or more years ago
Colonoscopy	○	○	○	○	○	○	○	○	○	○
Colon Polyp Removal	○	○	○	○	○	○	○	○	○	○
DEXA Scan	○	○	○	○	○	○	○	○	○	○
Diabetic Eye Exam	○	○	○	○	○	○	○	○	○	○
Mammogram	○	○	○	○	○	○	○	○	○	○
Prostate Exam (with PSA)	○	○	○	○	○	○	○	○	○	○

For technical support, please contact PatientLink at ***Support@MyPatientLink.com.***

Patient name: _____

Direction of Feed

Patient History

Please answer every question

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

SOCIAL HISTORY

TOBACCO

What is your smoking status? current (every day) ○ previous ○ current (some days) ○ 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+ ○

If you quit, how many years ago did you quit? less than 5 ○ 5 ○ 10 ○ 15 ○ 20 ○ 25 ○ 30 ○ 35 ○ 40+ ○

If you currently smoke, do you have a desire to quit? yes ○ no ○

Are you exposed to passive (secondhand) **smoke?** yes ○ no ○

ALCOHOL

Do you consume alcohol? currently ○ in the past ○ never (If you select "never", skip ahead to **DRUGS** section.) ○

If so, how much (now or in the past)**?** daily ○ 4-6 times per week ○ up to 3 times per week ○ less than once per week ○ social occasions ○

please fold on dotted line

If you quit, how many years ago did you quit? less than 5 ○ 5 ○ 10 ○ 15 ○ 20 ○ 25 ○ 30 ○ 35 ○ 40+ ○

If you *currently* consume alcohol, please answer the next four questions:

Have you ever felt you should cut down on your drinking? yes ○ no ○

Have people annoyed you by criticizing your drinking? yes ○ no ○

Have you ever felt bad or guilty about your drinking? yes ○ no ○

Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? yes ○ no ○

DRUGS

Have you used recreational drugs? currently ○ in the past ○ never ○

If so, how much (now or in the past)**?** daily ○ 4-6 times per week ○ up to 3 times per week ○ less than once per week ○

If you quit, how many years ago did you quit? less than 5 ○ 5 ○ 10 ○ 15 ○ 20 ○ 25 ○ 30 ○ 35 ○ 40+ ○

CAFFEINE

Do you drink caffeinated beverages? currently ○ in the past ○ never ○

If so, how much (now or in the past)**?** daily ○ 4-6 times per week ○ up to 3 times per week ○ less than once per week ○

EXERCISE

Do you exercise regularly? currently ○ in the past ○ never ○

If yes, how much? daily ○ 4-6 times per week ○ up to 3 times per week ○ less than once per week ○

please fold on dotted line

DEMOGRAPHICS

Race: American Indian / Alaska Native ○ Asian ○ Black / African American ○ Native Hawaiian / Pacific Islander ○ White / Caucasian ○ Decline to answer ○

Ethnicity: Hispanic or Latino ○ Not Hispanic or Latino ○ Decline to answer ○

Primary language: English ○ Spanish ○ **Other:** _____

DIET

If you are on a special diet, please describe:

_____

TRAVEL

Have you recently traveled outside of the country? no ○ yes ○

If yes, where: _____

Do you live in more than one location throughout the year? no ○ yes ○

If yes, please remember to provide us with alternate contact and provider information.