Print in Color or Grayscale Only
Using Adobe Acrobat Reader 8.0 or later

Personal / Family History

Please answer every question.

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

Marking Instructions

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

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:
10 20 30
1 2 3

10 20 30 40 50 60 70 80 90
1 2 3 4 5 6 7 8 9

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 ○

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 ○ rarely ○ occasionally ○ frequently ○

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

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Personal / Family History

Please answer every question.

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