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

Patient History

Please answer every question

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

PLEASE PRINT PATIENT'S LAST NAME

PATIENT'S FIRST NAME | MIDDLE INITIAL | 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)		previous
If you answer "never", skip ahead to "Does anyone in your household smoke?"	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+

Does anyone in your household smoke?		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+

OTHER

IV drug use or other recreational drug use?	currently	in the past	never
Have you ever had a blood transfusion?		yes	no
How often do you exercise? (times per week)	occasionally	1-2	5-6
	0	3-4	7
Do you always wear a seat belt?		yes	no

SURGICAL HISTORY

Please mark all surgeries you have had:

- **I HAVE HAD NO SURGERIES**
- Appendectomy
- Breast Augmentation
- Breast Lumpectomy
- Breast Reduction
- Carotid Artery
- Cataract
- 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):_____

PREVENTATIVE HEALTH

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

STAFF: **This section must be manually entered**

	N/A	1 year 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+ years ago	Were the results: Normal	Abnormal	Don't Know
Mammogram														
Colonoscopy														
Pap Smear														
Bone Density / Dexa Scan														
Prostate Cancer Screening														
Stool Hemoccult (blood in stool)														
Eye Exam														

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Patient History

Please answer every question

STAFF: *Responses in boxed bubbles and 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	
○	○	Alcohol Abuse	○	○	High Blood Pressure
○	○	Allergies / Sinus	○	○	High Cholesterol
○	○	Alzheimers	○	○	HIV / AIDS
○	○	Anemia	○	○	Hypothyroid (Low Thyroid)
○	○	Anxiety	○	○	Irritable Bowel Syndrome (IBS)
○	○	Arthritis	○	○	Kidney Stones
○	○	Asthma	○	○	Liver Cancer
○	○	Birth Defects	○	○	Lung Cancer
○	○	Bleeding Disease	○	○	Lupus
○	○	Blood Clots	○	○	Migraines
○	○	Breast Cancer	○	○	Multiple Sclerosis
○	○	Bipolar Disorder	○	○	Osteoporosis
○	○	Cataracts	○	○	Parkinson's Disease
○	○	Colon Cancer	○	○	Prostate Cancer
○	○	Congestive Heart Failure	○	○	Prostate Problems
○	○	COPD / Emphysema	○	○	Reflux / GERD
○	○	Coronary Artery Disease	○	○	Rheumatic Fever
○	○	Crohn's Disease	○	○	Rheumatoid Arthritis
○	○	Depression	○	○	Seizures / Convulsions
○	○	Diabetes Type 1	○	○	Sexually Transmitted Disease
○	○	Diabetes Type 2 (adult onset)	○	○	Sleep Apnea
○	○	Gout	○	○	Stomach Ulcer
○	○	Heart Attack	○	○	Stroke / CVA of the Brain
○	○	Hepatitis B	○	○	Suicide Attempt
○	○	Hepatitis C	○	○	Tuberculosis (TB)

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

_____

FAMILY MEDICAL HISTORY

○ **ADOPTED**

○ **FAMILY HISTORY UNKNOWN**

○ **NO SIGNIFICANT FAMILY MEDICAL HISTORY**

○ **Mother**, **Grandmother,** or **Sister** developed Heart Disease before the age of **65**.

○ **Father**, **Grandfather**, or **Brother** developed Heart Disease before the age of **55**.

Please indicate which family member(s) have had these illnesses:

	Father	Mother	Grandmother (Mother's side)	Grandfather (Mother's side)	Grandmother (Father's side)	Grandfather (Father's side)	Brother	Sister
Alcohol Abuse	○	○	○	○	○	○	○	○
Anemia	○	○	○	○	○	○	○	○
Arthritis	○	○	○	○	○	○	○	○
Asthma	○	○	○	○	○	○	○	○
Bipolar Disorder	○	○	○	○	○	○	○	○
Bleeding Disease	○	○	○	○	○	○	○	○
Breast Cancer	○	○	○	○	○	○	○	○
Colon Cancer	○	○	○	○	○	○	○	○
COPD / Emphysema	○	○	○	○	○	○	○	○
Depression	○	○	○	○	○	○	○	○
Diabetes Type 1	○	○	○	○	○	○	○	○
Diabetes Type 2 (adult onset)	○	○	○	○	○	○	○	○
High Blood Pressure	○	○	○	○	○	○	○	○
High Cholesterol	○	○	○	○	○	○	○	○
Osteoporosis	○	○	○	○	○	○	○	○
Seizures / Convulsions	○	○	○	○	○	○	○	○
Stroke / CVA of the Brain	○	○	○	○	○	○	○	○
Lung Cancer	○	○	○	○	○	○	○	○

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

_____