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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

PATIENT'S FIRST NAME | MIDDLE INITIAL | PATIENT'S DATE OF BIRTH (Month / Day / Year)

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 ○	

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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

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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
Mammogram	○	○	○	○	○	○	○	○	○	○	○
Colonoscopy	○	○	○	○	○	○	○	○	○	○	○
Pap Smear	○	○	○	○	○	○	○	○	○	○	○
Bone Density / Dexa Scan	○	○	○	○	○	○	○	○	○	○	○
Prostate Cancer Screening	○	○	○	○	○	○	○	○	○	○	○
Stool Hemoccult (blood in stool)	○	○	○	○	○	○	○	○	○	○	○
Eye Exam	○	○	○	○	○	○	○	○	○	○	○

Were the results:

Normal	Abnormal	Don't Know
○	○	○
○	○	○
○	○	○
○	○	○
○	○	○
○	○	○
○	○	○

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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

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○	○	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**

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	○	○	○	○	○	○	○	○

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○ **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**.

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

_____

_____

_____

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	○	○	○	○	○	○	○	○