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...

TOBACCO USE

How would you describe your cigarette smoking? — 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?

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

EXAMPLE
If you started smoking at the age of 21, you would fill in the ovals like this:
10 20 30
1 2 3

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 ○

(If you marked "never", please skip to Drug Use section)

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 ○ occasionally ○ rarely ○ frequently ○

DRUG USE

none ○ current ○ previous ○ prefer to discuss with physician ○

HIV HIGH RISK BEHAVIOUR?

(HIV Risk Factors: IV drug use, More than one sexual partner, Sex with a prostitute, Unprotected sexual contact, Contact with contaminated injection equipment.)

yes ○ no ○ prefer to discuss with physician ○

HABITS

Caffeine — -type(s) of caffeine: coffee ○ tea ○ soft drinks ○ — -drinks per day: occasionally ○ 0 ○ 1-2 ○ 3-4 ○ 5-6 ○ 7+ ○

Exercise — -type(s) of exercise: bicycling ○ running ○ swimming ○ walking ○ aerobics ○ other ○ — -times per week: occasionally ○ 0 ○ 1-2 ○ 3-4 ○ 5-6 ○ 7+ ○

How often do you wear a seatbelt? — always ○ almost always ○ occasionally ○ never ○

Sun Exposure: — occasionally ○ frequently ○ rarely ○

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PATIENT MEDICAL HISTORY

Please indicate if **YOU** have a history of the following.
Mark all that apply – mark "**NONE**" if none apply.

- ◯ Abnormal heart rhythm or EKG
- ◯ Anxiety / depression
- ◯ Arthritis
- ◯ Blood clots
- ◯ Blood disease
- ◯ Cancer (any kind)
- ◯ Congestive heart failure
- ◯ Convulsions or epilepsy
- ◯ Diabetes
- ◯ Emphysema / asthma
- ◯ Glaucoma / cataracts
- ◯ Heart attack
- ◯ Heart murmur
- ◯ Heart valve disease
- ◯ Hepatitis
- ◯ High blood pressure
- ◯ High cholesterol or triglycerides
- ◯ Leg circulation problem
- ◯ Kidney disease
- ◯ Liver disease
- ◯ Lung disease
- ◯ Prostate disease
- ◯ Psychiatric problems
- ◯ Rheumatic fever
- ◯ Stomach ulcers
- ◯ TIA / stroke
- ◯ Thyroid disease
- ◯ Tuberculosis
- ◯ Varicose veins
- ◯ **NONE**

PATIENT SURGICAL HISTORY

Please indicate if **YOU** have had any of the following surgeries.
Mark all that apply – mark "**NONE**" if none apply.

- ◯ Aneurysm repair
- ◯ Appendectomy
- ◯ Blood vessel surgery
- ◯ Breast surgery
- ◯ Cataract surgery
- ◯ Carotid surgery / stent
- ◯ Coronary bypass
- ◯ Defibrillator implant
- ◯ Gallbladder surgery
- ◯ Heart angioplasty / stent
- ◯ Heart valve surgery
- ◯ Hernia repair
- ◯ Hysterectomy
- ◯ Orthopedic surgery
- ◯ Ovaries removed
- ◯ Pacemaker implant
- ◯ Plastic surgery
- ◯ Prostate surgery
- ◯ Vascular stent
- ◯ **NONE**

FAMILY MEDICAL HISTORY

Please answer the following questions regarding your **FAMILY HISTORY**.

◯ **Family History Unknown**

Please indicate which family members have had these illnesses.

	Father	Mother	Sibling
abnormal heart rhythm	◯	◯	◯
cancer	◯	◯	◯
congenital heart disease	◯	◯	◯
diabetes	◯	◯	◯
heart disease	◯	◯	◯
high blood pressure	◯	◯	◯
stroke	◯	◯	◯
sudden death	◯	◯	◯
valve disease	◯	◯	◯

◯ **NONE** of the above illnesses

Mother is... ◯ alive ◯ deceased ◯ unknown

If **mother** is deceased:

...died of... ◯ heart attack / sudden death ◯ other

...at age... ◯ before 65 ◯ 65+

Father is... ◯ alive ◯ deceased ◯ unknown

If **father** is deceased:

...died of... ◯ heart attack / sudden death ◯ other

...at age... ◯ before 55 ◯ 55+

◯ Mother, Grandmother, or Sister developed heart disease before the age of 65
◯ Father, Grandfather, or Brother developed heart disease before the age of 55

PATIENT STATUS

Please indicate **YOUR** current living situation:

◯ living alone ◯ living with family / friends ◯ living in an assisted living facility