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

Direction of Feed

Personal / Family History

Please answer every question

STAFF: *Handwritten items must be entered* ***MANUALLY****. Do not fold this form.*

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

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 ○

(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 ○ rarely ○ occasionally ○ frequently ○

DRUG USE

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

HIV HIGH RISK BEHAVIOR?

(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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Direction of Feed

Personal / Family History

Please answer every question

STAFF: *Handwritten items must be entered* ***MANUALLY****. Do not fold this form.*

YOUR Medical History

Please indicate if YOU have a history of the following:

- ◯ Alcohol Abuse
- ◯ Anemia
- ◯ Anesthetic Complication
- ◯ Anorexia / Eating Disorder
- ◯ Anxiety Disorder
- ◯ Arthritis
- ◯ Asthma
- ◯ Autoimmune Problems
- ◯ Birth Defects
- ◯ Bladder Problems
- ◯ Bleeding Disease
- ◯ Blood Clots
- ◯ Blood Transfusion(s)
- ◯ Breast Cancer
- ◯ Cervical Cancer
- ◯ Colon Cancer
- ◯ Crohn's Disease
- ◯ Depression
- ◯ Diabetes
- ◯ Gallstones
- ◯ Growth / Development Disorder
- ◯ Heart Attack
- ◯ Heart Disease
- ◯ Hepatitis A
- ◯ Hepatitis B
- ◯ Hepatitis C
- ◯ High Blood Pressure
- ◯ High Cholesterol
- ◯ HIV
- ◯ Kidney Disease
- ◯ Liver Cancer
- ◯ Liver Disease
- ◯ Lung Cancer
- ◯ Lung / Respiratory Disease
- ◯ Mental Illness
- ◯ Migraines
- ◯ Osteoporosis
- ◯ Ovarian Cancer
- ◯ Prostate Cancer
- ◯ Rectal Cancer
- ◯ Reflux / GERD
- ◯ Seizures / Convulsions
- ◯ Severe Allergy
- ◯ Sexually Transmitted Disease
- ◯ Skin Cancer
- ◯ Sleep Apnea
- ◯ Stroke / CVA of the Brain
- ◯ Suicide Attempt
- ◯ Thyroid Problems
- ◯ Tuberculosis / Histoplasmosis
- ◯ Ulcer
- ◯ Ulcerative Colitis
- ◯ Other Disease, Cancer, or Significant Medical Illness
- ◯ **NONE of the Above**

FAMILY Medical History

Please indicate which family members have had these illnesses:

- ◯ **FAMILY HISTORY UNKNOWN**
- ◯ **NO SIGNIFICANT FAMILY HISTORY**

Mother	Father	Sister	Brother	Daughter	Son	
◯	◯	◯	◯	◯	◯	Alcohol Abuse
◯	◯	◯	◯	◯	◯	Anemia
◯	◯	◯	◯	◯	◯	Anesthetic Complication
◯	◯	◯	◯	◯	◯	Arthritis
◯	◯	◯	◯	◯	◯	Asthma
◯	◯	◯	◯	◯	◯	Bladder Problems
◯	◯	◯	◯	◯	◯	Bleeding Disease
◯	◯	◯	◯	◯	◯	Breast Cancer
◯	◯	◯	◯	◯	◯	Colon Cancer
◯	◯	◯	◯	◯	◯	Crohn's Disease
◯	◯	◯	◯	◯	◯	Depression
◯	◯	◯	◯	◯	◯	Diabetes
◯	◯	◯	◯	◯	◯	Heart Disease
◯	◯	◯	◯	◯	◯	Hemochromatosis
◯	◯	◯	◯	◯	◯	High Blood Pressure
◯	◯	◯	◯	◯	◯	High Cholesterol
◯	◯	◯	◯	◯	◯	Kidney Disease
◯	◯	◯	◯	◯	◯	Liver Disease
◯	◯	◯	◯	◯	◯	Lung / Respiratory Disease
◯	◯	◯	◯	◯	◯	Migraines
◯	◯	◯	◯	◯	◯	Osteoporosis
◯	◯	◯	◯	◯	◯	Rectal Cancer
◯	◯	◯	◯	◯	◯	Seizures / Convulsions
◯	◯	◯	◯	◯	◯	Severe Allergy
◯	◯	◯	◯	◯	◯	Stroke / CVA of the Brain
◯	◯	◯	◯	◯	◯	Thyroid Problems
◯	◯	◯	◯	◯	◯	Ulcerative Colitis
◯	◯	◯	◯	◯	◯	Other Cancer

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