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

Patient History

Please answer every question.

STAFF: Handwritten responses must be entered **MANUALLY**.

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) ○ previous ○
current (some days) ○ 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 ○ <½ ○ ½ ○
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 ahead 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 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 ○ occasionally ○ almost always ○ never ○

Sun exposure: occasionally ○ frequently ○ rarely ○

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

Patient History

Please answer every question.

STAFF: Handwritten responses must be entered **MANUALLY**.

PATIENT MEDICAL HISTORY

Please indicate if YOU have a history of the following:

- Alcohol Abuse
- Anemia
- Anesthetic Complication
- Anxiety Disorder
- Arthritis
- Asthma
- Autoimmune Problems
- Birth Defects
- Bladder Problems
- Bleeding Disease
- Blood Clots
- Blood Transfusion(s)
- Bowel Disease
- Breast Cancer
- Cervical Cancer
- Colon Cancer
- Depression
- Diabetes
- Growth / Development Disorder
- Heart Attack
- Heart Disease
- Heart Pain / Angina
- Hepatitis A
- Hepatitis B
- Hepatitis C
- High Blood Pressure
- High Cholesterol
- HIV
- Hives
- Kidney Disease
- Liver Cancer
- Liver Disease
- Lung / Respiratory Disease
- Lung Cancer
- Mental Illness
- Migraines
- Osteoporosis
- Prostate Cancer
- Rectal Cancer
- Reflux / GERD
- Seizures / Convulsions
- Severe Allergy
- Sexually Transmitted Disease (STD)
- Skin Cancer
- Stroke / CVA of the Brain
- Suicide Attempt
- Thyroid Problems
- Ulcer
- Other Disease, Cancer, or Significant Medical Illness (please specify): _____
- **NONE OF THE ABOVE**

ALLERGIES

Please indicate if you are allergic to any of the following:

Are you allergic to any drugs / medications?

- **I HAVE NO KNOWN ALLERGIES TO MEDICATIONS**
- Aspirin
- Codeine
- Morphine
- NSAIDS (e.g., ibuprofen, naproxen, etc.)
- Penicillin
- Sulfa
- Other (please specify): _____

Are you allergic to any environmental allergens?

- **I HAVE NO KNOWN ENVIRONMENTAL ALLERGIES**
- Animal Dander
- Bee Stings
- Eggs
- Food Dye
- Latex
- Milk
- Mold
- Nuts
- Pollen
- Shellfish
- Soya (soy)
- Wheat
- Other (please specify): _____

FAMILY MEDICAL HISTORY

Please indicate if YOUR FAMILY has a history of the following.
(ONLY include parents, grandparents, siblings, and children.)

- **FAMILY HISTORY UNKNOWN**
- Alcohol Abuse
- Anemia
- Anesthetic Complication
- Arthritis
- Asthma
- Bladder Problems
- Bleeding Disease
- Breast Cancer
- Colon Cancer
- Depression
- Diabetes
- Heart Disease
- High Blood Pressure
- High Cholesterol
- Kidney Disease
- Lung / Respiratory Disease
- Migraines
- Osteoporosis
- Rectal Cancer
- Seizures / Convulsions
- Severe Allergy
- Stroke / CVA of the Brain
- Thyroid Problems
- Other Cancer (please specify): _____
- **NONE OF THE ABOVE**

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