Do not write, stamp, punch holes or affix a sticker in this area.

Patient History

Please answer every question

To reproduce, follow the printing instructions. Do not fold this form.

Marking Instructions

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?

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 ◯

If you quit smoking, at what age did you quit?

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+ ◯

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)

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: coffee ◯ tea ◯ soft drinks ◯

Exercise: bicycling ◯ running ◯ swimming ◯ walking ◯ aerobics ◯ other ◯

Sun Exposure: occasionally ◯ frequently ◯ rarely ◯

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SAMPLE

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Patient History

Please answer every question

To reproduce, follow the printing instructions. Do not fold this form.

YOUR Medical History

Please indicate if **YOU** have a history of the following:

- Abdominal Aortic Aneurysm
- Alcohol Abuse
- Anemia
- Anesthetic Complication
- Anxiety Disorder
- Arthritis
- Asthma
- Autoimmune Problems
- Birth Defects
- Bladder Problems
- Bleeding Disease
- Blood Clots
- Bowel Disease
- Breast Cancer
- Cervical Cancer
- Colon Cancer
- Cosmetic Injections / Fillers
- Depression
- Diabetes
- Growth / Development Disorder
- Heart Disease
- Hepatitis
- High Blood Pressure
- High Cholesterol
- HIV/AIDS
- Kidney Disease
- Liver Cancer
- Liver Disease
- Lung / Respiratory Disease
- Lung Cancer
- Mental Illness
- MRSA (Methacillin Resistant Staphlococcus Aureus)
- Migraines
- Osteoporosis
- Prostate Cancer
- Reflux / GERD
- Seizures / Convulsions
- Skin Cancer
- Stroke / CVA of the Brain
- Suicide Attempt
- Thyroid Problems
- Varicose Veins
- Other Disease, Cancer, or Significant Medical Illness
- **NONE of the Above**

FAMILY Medical History

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

- **Family History Unknown**

- Abdominal Aortic Aneurysm
- Alcohol Abuse
- Anemia
- Anesthetic Complication
- Arthritis
- Blood Clots
- Breast Cancer
- Colon Cancer
- Diabetes
- Heart Disease
- High Blood Pressure
- High Cholesterol
- Kidney Disease
- Lung / Respiratory Disease
- Seizures / Convulsions
- Stroke / CVA of the Brain
- Thyroid Problems
- Other Cancer
- **NONE of the Above**

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