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Personal / Family History

Please answer every question.

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

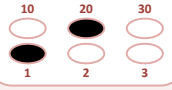
PATIENT'S DATE OF BIRTH (Month / Day / Year)

Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...

EXAMPLE

If you started smoking at the age of 21, you would fill in the ovals like this:



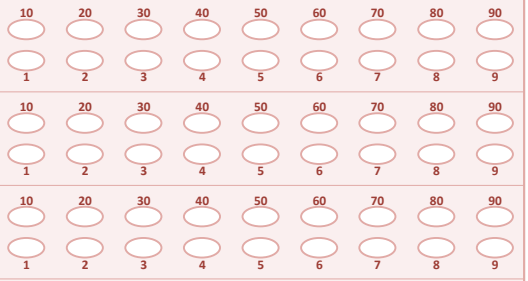
Tobacco Use

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?



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 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 ○

(U.S. Patent No. 7,487,102) (U.S. Patent No. 7,941,328)

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SAMPLE

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Personal / Family History

Please answer every question.

YOUR 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
- Mouth, Throat or Neck Cancer
- Osteoporosis
- Prostate Cancer
- Radiation Exposure
- Rectal Cancer
- Reflux / GERD
- Seizures / Convulsions
- Severe Allergy
- Sexually Transmitted Disease
- Skin Cancer
- Stroke / CVA of the Brain
- Suicide Attempt
- Thyroid Problems
- Ulcer
- 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**

- 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

- **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

SAMPLE
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