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

*Handwritten items must be entered **MANUALLY**.*

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

What is your smoking status? never ○ previous ○ current (some days) ○ current (every day) ○

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

please fold on dotted line

How many cigars or pipes do you smoke per week?
none ○ <1 ○ 1-2 ○ 3-5 ○ 6-9 ○ 10+ ○

How many cans of smokeless / chewing tobacco do you use per week?
none ○ <½ ○ ½ ○ 1 ○ 2 ○ 3+ ○

Are you exposed to secondhand smoke? no ○ yes ○

ALCOHOL USE

How often do you drink alcohol?
(If you marked "**never**", skip ahead to the **Drug Use** section.)

Number of times: never ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7+ ○

Per: day ○ week ○ month ○ year ○

What type(s) of alcohol do you drink? beer ○ wine ○ liquor ○

When you drink, how many drinks do you have? 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 ○ previous ○
current ○ 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.)

no ○ prefer to discuss ○
yes ○ with physician

OTHER

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

please fold on dotted line

Sun Exposure: occasionally ○ frequently ○ rarely ○

Marital status: single ○ married ○ divorced ○ widowed ○

Do you have religious or cultural needs related to your care? yes ○ no ○

Do you use any of the following? (Mark all that apply.)
no ○ wheelchair / motorized scooter ○ walker ○ crutches ○
cane ○ prosthesis ○ brace ○

Are you pregnant, or is it possible that you may be pregnant? yes ○ no ○

Are you able to perform activities of daily living (going to the bathroom, bathing, dressing, etc...)**?** yes ○ no ○

Caffeine
Type(s) of caffeine: coffee ○ tea ○ soft drinks ○
Drinks per day: none ○ occasional ○ 1-2 ○ 3-4 ○ 5-6 ○ 7+ ○

Exercise
Type(s) of exercise: bicycling ○ running ○ swimming ○ walking ○ aerobics ○ other ○
Times per week: none ○ occasional ○ 1-2 ○ 3-4 ○ 5-6 ○ 7+ ○

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Direction of Feed

Personal / Family History

Please answer every question

*Handwritten items must be entered **MANUALLY**.*

PAST MEDICAL HISTORY

Please indicate if YOU have a history of the following:

Patient name: _____

- ◯ Abnormal Heart Rhythm
- ◯ Alcohol Abuse
- ◯ Anemia
- ◯ Anesthetic Complication
- ◯ Anxiety Disorder
- ◯ Aphasia (difficulty speaking, writing, listening, reading)
- ◯ Arthritis
- ◯ Asthma
- ◯ Autoimmune Problems
- ◯ Birth Defect(s)
- ◯ Bladder Problems
- ◯ Bleeding Disease
- ◯ Cervical Cancer
- ◯ Colon Cancer
- ◯ COPD
- ◯ Deafness
- ◯ Depression
- ◯ Diabetes
- ◯ Disc Herniations
- ◯ Dysphagia (difficulty swallowing)
- ◯ Emphysema
- ◯ Fractures
- ◯ Gangrene
- ◯ Glaucoma
- ◯ Hepatitis A
- ◯ Hepatitis B
- ◯ Hepatitis C
- ◯ High Blood Pressure
- ◯ High Cholesterol
- ◯ HIV
- ◯ Hives
- ◯ Kidney Disease
- ◯ Liver Cancer
- ◯ Liver Disease
- ◯ Lung Cancer
- ◯ Lung / Respiratory Disease
- ◯ Lyme Disease
- ◯ Mental Illness
- ◯ Rectal Cancer
- ◯ Retinal Disease
- ◯ Reflux / GERD
- ◯ Seizures / Convulsions
- ◯ Severe Allergy
- ◯ Sexually Transmitted Disease (STD)
- ◯ Skin Cancer
- ◯ Stroke / CVA of the Brain / TIA
- ◯ Suicide Attempt
- ◯ Thyroid Problems

please fold on dotted line

- ◯ Blindness
- ◯ Blood Clots
- ◯ Blood Transfusion(s)
- ◯ Bowel Disease
- ◯ Breast Cancer
- ◯ Cataract(s)
- ◯ Cerebral Palsy
- ◯ Cerebrovascular Disease (AVM, aneurysm)
- ◯ Growth / Development Disorder
- ◯ Head Injury
- ◯ Heart Attack
- ◯ Heart Disease
- ◯ Heart Murmur
- ◯ Heart Pain / Angina
- ◯ Hemiparesis (right or left sided weakness)
- ◯ Miscarriages / Pregnancy Complications
- ◯ Migraines
- ◯ Multiple Sclerosis
- ◯ Osteoporosis
- ◯ Parkinson's Disease
- ◯ Peripheral Vascular Disease
- ◯ Pulmonary Embolism
- ◯ Prostate Cancer
- ◯ Transfusion
- ◯ Tuberculosis
- ◯ Ulcer
- ◯ Varicose Veins
- ◯ **Other Disease, Cancer, or Significant Medical Illness**

◯ **NO SIGNIFICANT MEDICAL HISTORY**

SURGICAL HISTORY

Please mark all surgeries you have had:

◯ **I HAVE HAD NO SURGERIES** (Skip to Family History)

left	right	both	
◯	◯	◯	**Lung Surgery**
◯	◯	◯	**Varicose Vein**
◯	◯	◯	**Mastoidectomy**
◯	◯	◯	**Kidney Removal**

left	right	both	
◯	◯	◯	**Cataract Surgery**
◯	◯	◯	**Breast Cancer Lump Removal**
◯	◯	◯	**Mastectomy**
◯	◯	◯	**Breast Reconstruction**
◯	◯	◯	**Breast Reduction**
◯	◯	◯	**Ovary Removal**
◯	◯	◯	**Carpal Tunnel Surgery**

left	right	both	
◯	◯	◯	**Rotator Cuff Repair**
◯	◯	◯	**Arthroscopic Shoulder**
◯	◯	◯	**Hip Fracture & Surgery**
◯	◯	◯	**Total Hip Replacement**
◯	◯	◯	**Arthroscopic Knee**
◯	◯	◯	**Total Knee Replacement**
◯	◯	◯	**Foot Surgery**

please fold on dotted line

Prostate Surgery	◯ TURP	◯ Removal
Gallbladder Surgery	◯ Open	◯ Laparoscopic
Colon Polyp Removal	◯ Open	◯ Colonoscopy
Colon Removal	◯ Partial	◯ Complete
Hysterectomy (due to cancer)		◯ Partial ◯ Complete
Hysterectomy (not due to cancer)		◯ Partial ◯ Complete
Thyroid Removal	◯ Partial	◯ Total
Spinal Fusion	◯ Neck	◯ Lower Back
Spinal Decompression	◯ Neck	◯ Lower Back
Dilation and Curettage (D&C)		◯ Single ◯ Multiple

Cesarean Section	◯ 1	◯ 2 ◯ 3+
Heart Bypass	◯ 1 Vessel ◯ 3 Vessels	◯ 2 Vessels ◯ 4+ Vessels ◯ Unknown # of Vessels
Breast Biopsy	◯ Left ◯ Both	◯ Right ◯ Multiple Times
Carotid Artery	◯ Left ◯ Both	◯ Right ◯ Multiple Times
Open Inguinal Hernia	◯ Left ◯ Both	◯ Right ◯ Multiple Times
Laparoscopic Inguinal Hernia	◯ Left ◯ Both	◯ Right ◯ Multiple Times
Heart Valve Replacement	◯ Mitral ◯ Aortic	◯ Tricuspid ◯ Unknown Valve

Surgeries continued on page 3.

SURGICAL HISTORY continued

Please mark all surgeries you have had:

Patient name: _____

- ◯ Amputation
- ◯ Anal Fissure Repair
- ◯ Appendectomy
- ◯ Brain Surgery
- ◯ Deep Brain Stimulation
- ◯ Deviated Nose Septum
- ◯ Dorsal Rhizotomy
- ◯ Hemorrhoidectomy
- ◯ Intrathecal Pump Placement
- ◯ Intrathecal Pump Replacement
- ◯ Low Back Disc Surgery
- ◯ Neck Disc Surgery
- ◯ Pacemaker
- ◯ PICC Line
- ◯ Sinus Surgery
- ◯ Spinal Cord Stimulator
- ◯ Splatt Procedure
- ◯ Strabismus Surgery (diplopia)
- ◯ Tendon Lengthening
- ◯ Tendon Transfer
- ◯ Tonsillectomy
- ◯ Tubal Ligation
- ◯ Ulcer Surgery
- ◯ Vasectomy
- ◯ Ventriculoperitoneal Shunt (VPS)

Other Surgeries (please specify):

_____

_____

FAMILY MEDICAL HISTORY

Please indicate which family members have had these illnesses:

◯ **FAMILY HISTORY UNKNOWN** ◯ **NO SIGNIFICANT FAMILY MEDICAL HISTORY**

please fold on dotted line

	Father	Mother	Brother	Sister	Son	Daughter
Alcoholism / Alcohol Abuse	◯	◯	◯	◯	◯	◯
Anemia	◯	◯	◯	◯	◯	◯
Anesthetic Complication	◯	◯	◯	◯	◯	◯
Aneurysm	◯	◯	◯	◯	◯	◯
Arthritis	◯	◯	◯	◯	◯	◯
Asthma	◯	◯	◯	◯	◯	◯
Bladder Problems	◯	◯	◯	◯	◯	◯
Bleeding Disease	◯	◯	◯	◯	◯	◯
Brain Tumor	◯	◯	◯	◯	◯	◯
Breast Cancer	◯	◯	◯	◯	◯	◯
Colon Cancer	◯	◯	◯	◯	◯	◯
Dementia	◯	◯	◯	◯	◯	◯
Depression	◯	◯	◯	◯	◯	◯
Diabetes	◯	◯	◯	◯	◯	◯
Drug Abuse	◯	◯	◯	◯	◯	◯
Heart Disease	◯	◯	◯	◯	◯	◯
High Blood Pressure	◯	◯	◯	◯	◯	◯
High Cholesterol	◯	◯	◯	◯	◯	◯
Kidney Disease	◯	◯	◯	◯	◯	◯
Lung / Respiratory Disease	◯	◯	◯	◯	◯	◯
Mental Illness	◯	◯	◯	◯	◯	◯

please fold on dotted line

	Father	Mother	Brother	Sister	Son	Daughter
Migraines	◯	◯	◯	◯	◯	◯
Multiple Sclerosis	◯	◯	◯	◯	◯	◯
Neurodegenerative Disease	◯	◯	◯	◯	◯	◯
Osteoporosis	◯	◯	◯	◯	◯	◯
Parkinson's Disease	◯	◯	◯	◯	◯	◯
Rectal Cancer	◯	◯	◯	◯	◯	◯
Seizures / Convulsions	◯	◯	◯	◯	◯	◯
Severe Allergy	◯	◯	◯	◯	◯	◯
Stroke / CVA of the Brain / TIA	◯	◯	◯	◯	◯	◯
Thyroid Problems	◯	◯	◯	◯	◯	◯
Other Disease, Cancer, or Illness (please specify): _____	◯	◯	◯	◯	◯	◯

◯ **Mother, Grandmother, or Sister developed heart disease before the age of 65**

◯ **Father, Grandfather, or Brother developed heart disease before the age of 55**