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Direction of Feed

Personal / Family History

Please answer every question

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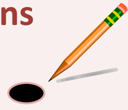
Marking Instructions

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

Are you exposed to secondhand smoke? no ◯ minimally ◯ frequently ◯ daily ◯

Please mark any tobacco products that you use: pipe ◯ cigars ◯ snuff ◯ chewing tobacco ◯

What is your current smoking status? never smoked ◯ former smoker ◯ currently smoke (some days) ◯ currently smoke (every day) ◯

If you never smoked or if you are a former smoker, please skip ahead to ***Alcohol Use [the next]*** *section.*

How many packs per day do you smoke? <1 ◯ 1 ◯ 1.5 ◯ 2 ◯ 2.5 ◯ 3 ◯ 3.5 ◯ 4 ◯ 4+ ◯

How many years have you been smoking? <1 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯ 11 ◯ 12 ◯ 13 ◯ 14 ◯ 15 ◯ 16 ◯ 17 ◯ 18 ◯ 19 ◯ 20 ◯ 21 ◯ 22 ◯ 23 ◯ 24 ◯ 25 ◯ 26 ◯ 27 ◯ 28 ◯ 29 ◯ 30 ◯ 30+ ◯

Do any of these statements apply to you? I would like to quit ◯ I have never tried to quit ◯ I have tried unsuccessfully in the past to quit ◯

ALCOHOL USE

How often do you drink alcohol? never ◯ occasionally ◯ moderately ◯ heavily ◯ quit recently ◯ quit a long time ago ◯

Type(s): beer ◯ wine ◯ liquor ◯

DRUG USE

How often do you use illicit drugs? never ◯ socially only ◯ daily ◯ weekly ◯ monthly ◯ yearly ◯ quit recently ◯ quit a long time ago ◯ prefer to discuss with provider ◯

Type(s): cocaine ◯ crack cocaine ◯ downers ◯ heroin ◯ IV drugs ◯ marijuana ◯ uppers ◯

CAFFEINE USE

Do you consume any of these? tea ◯ coffee ◯ carbonated beverages ◯

Servings per day: none ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 8+ ◯

EXERCISE

Number of times you exercise each week: none (inactive) ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ daily ◯

Type(s): walking ◯ running ◯ cycling ◯ yoga ◯ stretching ◯ exercise classes ◯ team sports ◯ yardwork ◯ housework ◯

SEATBELT USE

always ◯ almost always ◯ occasionally ◯ never ◯

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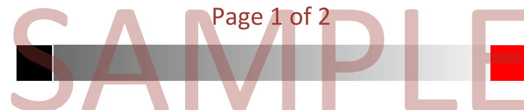

SAMPLE

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Direction of Feed

Personal / Family History

Please answer every question

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PAST MEDICAL HISTORY

Please indicate if YOU have a history of the following:

- Alcohol Abuse
- Anemia
- Anesthetic Complication
- Anxiety Disorder
- Arthritis
- Asthma
- Autoimmune Problems
- Birth Defect(s)
- 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 Cancer
- Lung / Respiratory Disease
- 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
- **NONE of the Above**

FAMILY MEDICAL HISTORY

- **Family History UNKNOWN**
- **NO SIGNIFICANT FAMILY MEDICAL HISTORY**

Please indicate which family members have had these illnesses:	Father	Mother	Brother	Sister	Son	Daughter
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						

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

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