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

Direction of Feed

Personal / Family History

Please answer every question

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

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) ○ current (some days) ○ previous ○ never ○

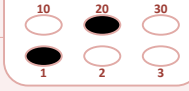
At what age did you begin smoking?

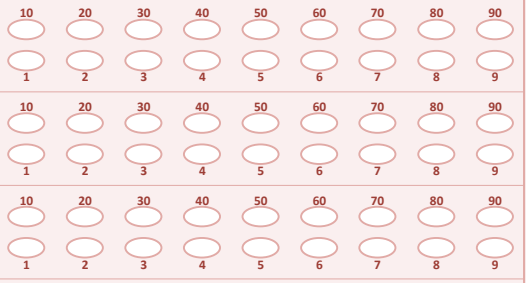
If you quit smoking, at what age did you quit?

How many cigarettes do you currently smoke (or did you previously smoke) **per day?**

EXAMPLE

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





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 ○ <1/2 ○ 1/2 ○ 1 ○ 2 ○ 3+ ○

Are you exposed to passive (second hand) **smoke?** yes ○ no ○

ALCOHOL USE

How often do you drink 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 ○ none ○ 1-2 ○ 3-4 ○ 5-6 ○ 7+ ○

Exercise

Type(s) of exercise: bicycling ○ running ○ swimming ○ walking ○ aerobics ○ other ○

Times per week: occasionally ○ none ○ 1-2 ○ 3-4 ○ 5-6 ○ 7+ ○

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

Sun Exposure: occasionally ○ frequently ○ rarely ○

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

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	◯	◯	◯	◯	◯	◯

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	◯	◯	◯	◯
Feeling down, depressed, or hopeless	◯	◯	◯	◯