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Personal / Family History

Please answer every question

*Handwritten items must be entered **MANUALLY**. Fold only on the dotted lines.*

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

PAST MEDICAL HISTORY

Please indicate if YOU have a history of the following:

- **NO Significant Medical History**
- Alcohol Abuse
- Anemia
- Anesthesia Complications
- Asthma
- Atrial Fibrillation
- Allergies
- Anxiety Disorder
- Depression
- Diabetes
- Emphysema
- Fibromyalgia
- Gastric Reflux (GERD)
- Gout
- Heart Attack
- Heart Disease
- Lung Cancer
- Lung Nodules (Benign)
- Collapsed Lung
- Lupus
- Melanoma
- Migraines
- Narcolepsy
- Pulmonary Fibrosis

please fold on dotted line

- Arthritis
- Blood Clots
- High Cholesterol
- Bleeding Disorder
- Breast Cancer
- Cervical Cancer
- Cirrhosis
- Colon Cancer
- Congestive Heart Failure
- COPD
- Heart Murmur
- High Blood Pressure
- HIV (AIDS)
- Hyperthyroidism (High Thyroid)
- Hypothyroidism (Low Thyroid)
- Insomnia
- Irritable Bowel Syndrome (IBS)
- Kidney Disease
- Kidney Stone
- Liver Disease
- Pulmonary Hypertension
- Prostate Cancer
- Rheumatoid Arthritis
- Sarcoidosis
- Seizures
- Sleep Apnea
- Skin Cancer (NOT Melanoma)
- Scleroderma
- Stroke / TIA (Mini Stroke)
- Stomach Ulcers
- Tuberculosis (TB)
- Positive Skin Test for TB

OTHER (please specify): _____

SURGICAL HISTORY

Please indicate if YOU have had any of the following surgeries:

- **I Have Had NO SURGERIES**
- Aneurysm Repair
- Appendectomy
- Back
- Bladder
- Breast
- CABG (Cardiac Bypass)
- Cataracts
- Colon
- Defibrillator / Pacemaker Placement
- Gallbladder
- Gastric Bypass or Lap Band
- Heart Angioplasty or Stent
- Heart Valve
- Hysterectomy
- Knee
- Lung
- Prostate
- Ovary Removal
- Cosmetic
- Sinus
- Stomach

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- Cardiac Stents
- Carotid Surgery or Stent
- Hip
- Hernia
- Tonsils
- Vascular Surgery or Stent

OTHER (please specify): _____

HABITS

How would you describe your cigarette smoking?

current (every day) ○ former ○
current (some days) ○ never ○

If you smoke(d), at what age did you begin smoking?

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

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

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Personal / Family History

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HABITS continued

Average number of cigarette packs smoked per day (now or in the past): ½ or less ◯ 1 ◯ 1 ½ ◯ 2 or more ◯

Do you use other tobacco products? cigars ◯ snuff ◯ dip / chewing tobacco ◯ electronic cigarettes ◯ **OTHER** (please specify): _____

Are you exposed to secondhand smoke? yes ◯ no ◯

How often do you drink alcohol? never ◯ daily ◯ on weekends ◯ a few days a week ◯ rarely ◯

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

How many drinks per occasion? 1-2 ◯ 3-5 ◯ more than 5 ◯

Recreational drug use: none ◯ current ◯ previous ◯ prefer to discuss with physician ◯

How many caffeinated beverages do you consume per day? 0 ◯ 1-2 ◯ 3-5 ◯ 6 or more ◯

How many times per week do you exercise? 0 ◯ 1-2 ◯ 3-4 ◯ 5-6 ◯ 7 or more ◯

What type(s) of exercise do you participate in? walking ◯ running ◯ biking ◯ aerobics ◯ swimming ◯ strength training ◯ **OTHER** (please specify): _____

please fold on dotted line

IMMUNIZATIONS

Date of last flu vaccine: _____ **Date of last pneumonia vaccine:** _____

FAMILY MEDICAL HISTORY

Please indicate which family member(s) have had these illnesses:

	Mother	Father	Son or Daughter	Sister or Brother	Aunt or Uncle	Grand parent
Asthma	◯	◯	◯	◯	◯	◯
Lung Cancer	◯	◯	◯	◯	◯	◯
Other Type of Cancer (please specify): _____	◯	◯	◯	◯	◯	◯
Cardiac Disease (Heart Attack / Stent / Bypass)	◯	◯	◯	◯	◯	◯
Congestive Heart Failure	◯	◯	◯	◯	◯	◯
COPD / Emphysema	◯	◯	◯	◯	◯	◯
Diabetes	◯	◯	◯	◯	◯	◯
High Blood Pressure	◯	◯	◯	◯	◯	◯
Rheumatoid Arthritis	◯	◯	◯	◯	◯	◯
Lupus	◯	◯	◯	◯	◯	◯
Sleep Apnea	◯	◯	◯	◯	◯	◯
Pulmonary Fibrosis	◯	◯	◯	◯	◯	◯
Pulmonary Artery Hypertension	◯	◯	◯	◯	◯	◯
Tuberculosis (TB)	◯	◯	◯	◯	◯	◯
Stroke	◯	◯	◯	◯	◯	◯
Blood Clot in Lung or Leg	◯	◯	◯	◯	◯	◯

please fold on dotted line

◯ **Family History UNKNOWN** ◯ **ADOPTED** ◯ **NO SIGNIFICANT FAMILY MEDICAL HISTORY**

SOCIAL HISTORY

Employment status: retired ◯ student ◯ homemaker ◯ disabled ◯ never employed ◯ unemployed ◯ employed part time ◯ employed full time ◯

Education: high school / GED ◯ trade school ◯ some college ◯ college degree ◯ masters degree / professional degree ◯

Marital status: single ◯ living with significant other ◯ married ◯ separated ◯ divorced ◯ widowed ◯

Have you ever been exposed to any of the following for more than one month at a time?

Agent Orange ◯ asbestos ◯ beryllium ◯ brake mechanic ◯ birds / chickens ◯ tuberculosis ◯ cotton mills ◯ mining ◯ pipe fitting ◯ shipyard ◯ stored hay or grain ◯ welding ◯

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