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Direction of Feed

Personal / Family History

Please answer every question

Handwritten items must be entered **MANUALLY**.
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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

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

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- ○ Arthritis
- ○ Blood Clots
- ○ Bronchiectasis
- ○ 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) ○ current (some days) ○ former ○ never

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

Tens: ○ 10 ○ 20 ○ 30 ○ 40 ○ 50 ○ 60 ○ 70 ○ 80 ○ 90
Ones: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9

EXAMPLE
If you started smoking at the age of 21, you would fill in the ovals like this:
○ 10 ● 20 ○ 30
● 1 ○ 2 ○ 3

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

Tens: ○ 10 ○ 20 ○ 30 ○ 40 ○ 50 ○ 60 ○ 70 ○ 80 ○ 90
Ones: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9

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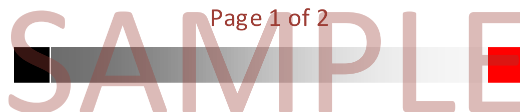

SAMPLE

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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	◯	◯	◯	◯	◯	◯

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◯ **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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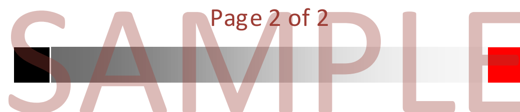

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